

91 21501

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAURE PIERRETTE WAMBACH</b>		2. DATE OF DEATH MONTH <b>AUG</b> DAY <b>5</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>5:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-38-2878</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs, last birthday) <b>79</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7-14-1912</b>		8. BIRTHPLACE (State or Foreign) <b>FRANCE</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>MERIDIAN HERITAGE NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>DUNDALK</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>DUNDALK</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>3453 DUNHAVEN ROAD</b>		10f. ZIP CODE <b>21222</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>N/A</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOME MAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>		17. FATHER'S NAME (First, Middle, Last) <b>BATHELEMI VALENTINOTTI</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARIE MATHIEU</b>		19a. INFORMANT'S NAME (Type/Print) <b>JOHN F. WAMBACH</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3453 DUNHAVEN ROAD BALTIMORE, MARYLAND 21222</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LORRAINE PARK CEMETERY 8-8-91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chad W. Lohr</i>		22. NAME AND ADDRESS OF FACILITY <b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>STROKE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>COPD</b>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theo C. Patterson M.D.</i>				29c. LICENSE NUMBER <b>D09643</b>	
29d. DATE SIGNED (Month, Day, Year) <b>AUG 7 1991</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>THEO C. PATTERSON M.D. 1576 Merrett Blvd 21222</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 7 1991</b>					
32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOPE OF THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

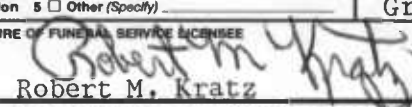
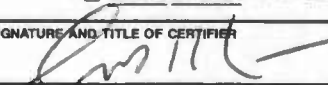
10215 10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and sent to the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										91 21502	
CERTIFICATE OF DEATH										REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Elinor M. Whelan</b>						2. DATE OF DEATH MONTH <b>08</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:20 a.m.</b>			
4. SOCIAL SECURITY NUMBER <b>213-42-3133A</b>		5. SEX <input checked="" type="checkbox"/> F <input type="checkbox"/> M	6. AGE (In yrs. last birthday) <b>94</b> YRS.	IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		7. DATE OF BIRTH (Month, Day, Year) <b>05/08/1897</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balt., MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Pickersgill Inc. 615 Chestnut</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson, MD 21204</b>		9c. COUNTY OF DEATH <b>Baltimore</b>			
RESIDENCE OF DECEDENT											
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>615 Chestnut Avenue</b>						10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Banking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edmund Jacobsen Whelan</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henrikka E. Mowinckel</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Stephanie R. King</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>615 Chestnut Avenue Towson MD 21204</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenmount Cemetery 8-6</b>				20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>Robert M. Kratz</b>						22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Road Baltimore, Maryland 21212</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death	
a. <b>SUDDEN CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):										IMMEDIATE	
b. <b>HYPERTENSIVE CARDIOMYOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF):										YEARS	
c. _____ DUE TO (OR AS A CONSEQUENCE OF):											
d. _____ DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS</b> <b>DEPRESSION</b>										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
										24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 						29c. LICENSE NUMBER <b>D23034</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <b>AUG 7 1991</b>				32. REGISTRAR'S SIGNATURE 							

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91 21503

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE H. ALLEN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>2</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2145</b> P M	
4. SOCIAL SECURITY NUMBER <b>213-12-8256</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-22-14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE Md</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Md.</b>			
10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO. City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2403 St. Stephens Ct.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>FREEMAN, Allen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LUCY JENNINGS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALICEAN C. ALLEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 St. Stephens Ct BALTO. Md 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARbutus Mem. PK</b>		20c. LOCATION — City or Town, State <b>BALTO. Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wm C. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. BROWN COMMUNITY F/H 1206 W. North Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Acute cardiovascular collapse</b>				Approximate interval between Onset and Death <b>30 minutes</b>	
		b. <b>Chronic atrial fibrillation</b>				<b>5-6 yrs</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		c. <b>Ischemic heart coronary artery disease</b>				<b>6 yrs</b>	
		d. <b>Insulin dependent diabetes mellitus</b>				<b>7-8 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Cervical stenosis</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ellis J. Berzon, M.D. Surgical Resident</b>				29c. LICENSE NUMBER <b>A52438528-726</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/2/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ellis J. Berzon, M.D. 900 S. Caton Ave, Baltimore, MD 21229</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 51203

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

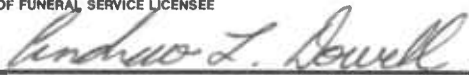

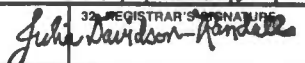
DMMH-16 Rev 1/89

91 31204

91 21505

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LOUIS M. BORN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-4-91</b>		3. TIME OF DEATH <b>7:15 AM</b>	
4. SOCIAL SECURITY NUMBER <b>216-32-8166</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-12-02</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS HOSPICE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		9c. COUNTY OF DEATH <b>BALTO.</b>	
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>337 S. Ellwood Ave.</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6 yrs.</b> College (1-4 or 5+) <b>Fireman</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Born</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Wacter</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles Born</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1307 Smeton Place, Towson, Md. 21204</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart Cemetery</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lilly &amp; Zeiler Inc. 700 S. Conkling St. 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28e. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>115904</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8-4-91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDDIE YAKUTUDA MD 2300 Dulaney Valley TOWSON, MD</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 21506

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Miriam Gertrude Bowers</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 5 1991</b>		3. TIME OF DEATH 10:30 P. M.	
4. SOCIAL SECURITY NUMBER <b>212-74-5379</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 10 1900</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph's Hospital</b>		9b. CITY TOWN OR LOCATION OF DEATH <b>Towson</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Towson</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>28 Alleghany Avenue</b>	
10f. ZIP CODE <b>21204</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James B. Young</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dora Finney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John S. Bowers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>28 Alleghany Avenue, Towson, Md. 21204</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>		20c. LOCATION — City or Town, State <b>Parkville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bryan W. Clary</i> <b>Bryan W. Clary</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld</b> <b>10 W. Padonia Rd., Timonium, Md. 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Large intra cerebral hemorrhage</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Subarachnoid hemorrhage</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b></b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Natividad D. de Leon, M.D.</i>				29c. LICENSE NUMBER <b>D1509</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NATIVIDAD D. DE LEON, C/O ST. JOSEPH HOSPITAL, TOWSON, MD. 21204</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This is to certify that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ARTEMAS REED BORT

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21507

1. DECEDENT'S NAME (First, Middle, Last) ARTEMAS REED BORT				2. DATE OF DEATH MONTH DAY YEAR AUGUST 4, 1991		3. TIME OF DEATH 8:06 A M	
4. SOCIAL SECURITY NUMBER 579-28-0421		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) MARCH 3, 1912	
8. BIRTHPLACE (State or Foreign Country) WASHINGTON, D.C.				9a. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		9c. COUNTY OF DEATH MONTGOMERY	
9b. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADVENTIST HOSPITAL							
10a. STATE MD.		10b. COUNTY MONTGOMERY		10c. CITY, TOWN OR LOCATION ROCKVILLE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 90 MONROE STREET #509				10f. ZIP CODE 20850		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+) 0		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MAINTENANCE		16b. KIND OF BUSINESS/INDUSTRY POLICE DEPARTMENT			
17. FATHER'S NAME (First, Middle, Last) HARRY J. BORT				18. MOTHER'S NAME (First, Middle, Maiden Surname) LILLIAN PHILLIPS			
19a. INFORMANT'S NAME (Type/Print) WILLIAM L. BORT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13519 TURKEY BRANCH PKWAY. ROCKVILLE, MD. 20853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) MT. ZION CEMETERY		20c. DATE 8/7		20d. LOCATION — City or Town, State BETHESDA, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				22. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE RD. LAYTONSVILLE, MD. 20882			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. VENTRICULAR ARRHYTHMIAS b. SUDDEN CARDIAC DEATH Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST c. d. Approximate Interval Between Onset and Death 5 MIN 10 MIN							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. STAPHYLOCOCCAL SEPSIS, OBESITY, PNEUMONIA							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Steven T. Kary MD				29c. LICENSE NUMBER D36252		29d. DATE SIGNED (Month, Day, Year) 8/4/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) STEVEN KARYA, MD, 4701 RANDOLPH ROAD #G3 ROCKVILLE MD 20852							
31. DATE FILED (Month, Day, Year) AUG 8 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4497-510

91 21508

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NICHOLAS M. CORNIAS</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>04</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220-74-1720</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>30</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-22-60</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>521 UMBRA STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>-</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>-</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>521 Umbra Street</b>			
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Refrigeration Equipment</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Michael Nick Cornias</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Despina Pikounis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael N. Cornias</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>803 Umbra Street, Baltimore, Md. 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oak Lawn Cemetery</b>		20c. DATE <b>8-7</b>		20d. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ann S. Matthews</i>				22. NAME AND ADDRESS OF FACILITY <b>Matthews Funeral Home</b> <b>3021 Eastern Ave., Baltimore, Md. 21224</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Narcotic Intoxication</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>Unknown</b>		28b. TIME OF INJURY <b>Unknown</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Unknown</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Unknown</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>521 Umbra St, Baltimore</b>							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Frank J. Pearlman</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-5-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK J. PEARLMAN 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4498-510

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) WALTER BERNARD CRIDDLE				2. DATE OF DEATH MONTH 8 DAY 5 YEAR 1991		3. TIME OF DEATH 2:16 A M	
4. SOCIAL SECURITY NUMBER 214-26-9674		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 06-06-1930	
8. BIRTHPLACE (State or Foreign Country) Balto., Md.				9a. FACILITY NAME (If not institution, give street and number) MERCY MEDICAL CENTER		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH N/A				10a. STATE Maryland		10b. COUNTY N/A	
10c. CITY, TOWN OR LOCATION Baltimore City				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 550 E. Madison Street	
10f. ZIP CODE 21202				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Alcoholism Counselor		16b. KIND OF BUSINESS/INDUSTRY University of Maryland	
17. FATHER'S NAME (First, Middle, Last) Walter Criddle				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Magdalene Rogers			
19a. INFORMANT'S NAME (Type/Print) Karen Criddle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8812 Pennsbury Place, Baltimore, Maryland 21237			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest		20c. LOCATION — City or Town, State 8/9 Owings Mills, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Hypertensive Atherosclerotic Cardiovascular Disease</i> b. <i>Disease</i> c. <i>Disease</i> d. <i>Disease</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Obesity</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <i>JAIL</i>			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 8-5-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK J. ARETTI, JR. 111 N. PENN STREET BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) AUG 8 1991				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 allows any injury, or other traumatic event, the medical examiner must be notified at once.

471

at 5120a




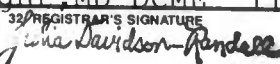
ITEM:4 per FH  
G-678 8/15/91 cm  
91-4501-510

91 21510

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gloria J. Dickson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 05 1991</b>		3. TIME OF DEATH <b>3:52 A M</b>			
4. <b>216-50-1554</b> <del>215-50-1554</del>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-25-49</b>			
8. BIRTHPLACE (State or Foreign Country) <b>NY.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>		10b. COUNTY			
10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3516 KENTUCKY AVE.</b>			
10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced			
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:					
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12TH</b>					
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>DAVID A. HAYDEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY L. WILLIAM</b>					
19a. INFORMANT'S NAME (Type/Print) <b>JAMES DICKSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3516 KENTUCKY AVE./BALTIMORE, MD 21213</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>CEDAR HILL CEMETARY</b>		20c. LOCATION — City or Town, State <b>ANNE ARUNDEL CO. MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiomyopathy</u></b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b><u>Hypertension</u></b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 05 1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>	
31. DATE FIED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21511

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IVES DARGAN</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>31</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>
4. SOCIAL SECURITY NUMBER <b>218-76-9118</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>57</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12 7 33</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9. FACILITY NAME (If not institution, give street and number) <b>827 Harlem Avenue</b>		
9a. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>827 Harlem Avenue</b>		
10f. ZIP CODE <b>21201</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>Sidney Miles</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Tonque</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Christine Dargan</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2000 McCulloh St. Baltimore, Maryland 21217</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 7/6/91 Arbutus, Maryland</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Deacy Harris</b>		22. NAME AND ADDRESS OF FACILITY <b>1701 McCulloh St. Chatman-Harris F/H Baltimore, MD 21217</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic coronary vascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Diabetes mellitus</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypothyroidism</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jamie Harris MD</b>		29c. LICENSE NUMBER <b>D41339</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/1/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMIE HARRIS MD 120 S. GREENE ST. BALTIMORE, MD 21201</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the cause of death has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the Bureau of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, of item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51211

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21512

1. DECEDENT'S NAME (First, Middle, Last) <b>BRANDON DELANO EXUM</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4 A M</b>	
4. SOCIAL SECURITY NUMBER <b>578-98-8335</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>28</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-29-63</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>10437 Beacon Ridge Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BOWIE</b>		9c. COUNTY OF DEATH <b>Prince George</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince George</b>		10c. CITY, TOWN OR LOCATION <b>BOWIE</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>10437 Beacon Ridge Drive</b>				10f. ZIP CODE <b>20716</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>1 year</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sea Food Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin D. Exum, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marion Paige</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Benjamin D. Exum, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10437 Beacon Ridge Dr. Mitchellville, MD 20716</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>George Washington Cemetery 8/19/91</b>		20c. LOCATION — City or Town, State <b>Adelphi, Maryland</b>		20d. DATE <b>8/19/91</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kimberly C. Briscoe</b>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acquired Immunodeficiency Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Could not be determined <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul A. DeVore, Deputy Medical Examiner</b>							
29c. LICENSE NUMBER <b>DO1852</b>				29d. DATE SIGNED (Month, Day, Year) <b>8-7-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE MD 4203 Queensbury Rd Hyattsville MD 20781</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 20 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51215

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21513			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) Dollie G. Fields				2. DATE OF DEATH MONTH 8 DAY 1 YEAR 91		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 212-24-5472		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 93 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 1 22 1898		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 2429 Harlem Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH					
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2429 Harlem Avenue				10f. ZIP CODE 21216		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) Jehu N. Govans				18. MOTHER'S NAME (First, Middle, Maiden Surname) Georgiana							
19a. INFORMANT'S NAME (Type/Print) Collins Shepherd				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 21215 3643 Wabash Avenue Baltimore, Maryland							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mt. Auburn Cemetery 8/5/91		DATE 8/5/91		20c. LOCATION — City or Town, State Baltimore, Md					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE ► <i>Henry Harris</i>				22. NAME AND ADDRESS OF FACILITY 1701 McCulloh St. Chatman-Harris F/H Baltimore, Md 21217							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>CONGESTIVE HEART FAILURE</u> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 8/1/91			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kelley J. Mitchell, MD.</i>		29c. LICENSE NUMBER D08143		29d. DATE SIGNED (Month, Day, Year) ► 8/1/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) AUG 8 1991		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

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91 21514

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JANE K FLANDERS</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>06</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>6:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>227-18-7591</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/16/1922</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>G.B.M.C., 6701 N. CHARLES STREET</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		8c. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. RESIDENCE OF DECEDENT <b>MARYLAND</b>				9b. CITY, TOWN OR LOCATION <b>BALTIMORE City</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>6016 BELLONA AVENUE</b>			
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Bookkeeper Ret.</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>J. T. Kimberling</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Snider</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Forrest Craig Flanders</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6016 Bellona Avenue Baltimore, Md. 21212</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 8/8/91</b>		20c. LOCATION — City or Town, State <b>Towson Maryland</b>		20d. DATE <b>8/8/91</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton Knight Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MUSCULAR DYSTROPHY</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>DEHYDRATION</b>							
c. <b>OTHER</b>							
d. <b>OTHER</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D23034</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Edward P. Koga MD; 6701 N. CHARLES ST; BALTIMORE, MD 21204</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR CLINIC: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. FURBAY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 03 1991</b>		3. TIME OF DEATH <b>09:35 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-28-0697</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 23 30</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1933 ST. PAUL STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1933 ST. PAUL STREET</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>HOUSEWIFE</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>MCGUIER</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>UNKNOWN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>TERRY CLATTERBUCK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3600 DURLEY LANE, BALTIMORE, MARYLAND 21207</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>A. Alan Seitz, Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DDA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 03 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD DCME 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

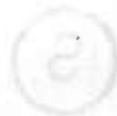
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JWR

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BOBBY GOOCH</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>04</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11 33P</b> M	
4. SOCIAL SECURITY NUMBER <b>225 34 7016</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 5, 1931</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Louisa County, VA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Prince George's Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Seat Pleasant</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6015 Martin Luther King Highway</b>	
10f. ZIP CODE <b>20743</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Govt.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Alanzy J. Gooch</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Jackson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernice E. Gooch</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6015 Martin Luther King Hwy. Seat Pleasant, MD 20743</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 8-8</b>		20c. LOCATION — City or Town, State <b>Landover, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. ACUTE RENAL FAILURE</b> <b>b. CONGESTIVE HEART FAILURE</b> <b>c. CORONARY ARTERY DISEASE</b> <b>d. VENTRICULAR TACHYARRHYTHMIA</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CARCINOMA KIDNEY</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Attn. Physician</b>				29c. LICENSE NUMBER <b>019897</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-59-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>V. SINGH 7209A Hanover Parkway Greenbelt Md 20770</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51219

91 21517

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Herbert HASKINS JR</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:04pm</b>	
4. SOCIAL SECURITY NUMBER <b>218-44-7614</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-5-46</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5645 PERDUE AVE. APT E</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>HERBERT HASKINS, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA DIGGS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GENEVA BOXDALE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>725 N. STREEPER STREET/BALTO., MD 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHELL MEM. GARDENS</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Overwhelming PCP PNEUMONIA</b>							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>AIDS</b>							
b. DUE TO (OR AS A CONSEQUENCE OF): <b>HIV +</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. C. Brown MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>08/03/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EVA C. BROWN University of Maryland Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on this certificate is to be used for the purpose of death certification only. It is not to be used for the purpose of death certification. The death certificate is to be completed by the attending physician or the funeral director. The death certificate is to be completed by the attending physician or the funeral director. The death certificate is to be completed by the attending physician or the funeral director.

TO THE FUNERAL DIRECTOR: After this certificate is completed, it is to be signed by the funeral director. The death certificate is to be completed by the attending physician or the funeral director. The death certificate is to be completed by the attending physician or the funeral director. The death certificate is to be completed by the attending physician or the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

01 51217



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows injury or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) Patsy L. Harding				2. DATE OF DEATH MONTH DAY YEAR August 3, 1991				3. TIME OF DEATH 6:38 P M							
4. SOCIAL SECURITY NUMBER 239-78-1077		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-26-47		8. BIRTHPLACE (State or Foreign Country) N.C.							
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT															
10a. STATE MD		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, MD				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER 830 HARLEM AVENUE				10f. ZIP CODE 21201				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) COLLEGE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) UNEMPLOYED				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) TILLER HARRIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ANNIE M. HARRIS											
19a. INFORMANT'S NAME (Type/Print) BEN HARDING				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 830 HARLEM AVE./BALTIMORE, MD 21201											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. LOCATION — City or Town, State CATONSVILLE, MD											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Calvin L. Williams				22. NAME AND ADDRESS OF FACILITY WM.C.MARCH F.H./1101 E. NORTH AVE.											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Richard Gregor MD				29c. LICENSE NUMBER N/A		29d. DATE SIGNED (Month, Day, Year) 8/31/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) R. Gregor, M.D. c/o Maryland General Hospital															
31. DATE FILED (Month, Day, Year) AUG 8 1991				32. REGISTRAR'S SIGNATURE John Davidson-Rendall											

01 21213

91 21519

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>WILLIAM HENRY HALL</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>03</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-8399</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-21-10</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1401 NORTH LAKEWOOD AVE APT 221</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>MD</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1401 NORTH LAKEWOOD AVE. 221</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th Grade</b> College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Fait Hall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Hall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael D. Fuller Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1133 McAleer Ct./Baltimore, Md. 21202</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet Cem.</b>		DATE		20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Warner</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac infarct</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>CoPD</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>cardiovascular disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): <b>anthrax</b> d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Shirley Gaymo SHERMAN, MD</b>				29c. LICENSE NUMBER <b>D-39102</b>		29d. DATE SIGNED (Month, Day, Year) <b>Aug 7 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>							
32. REGISTRAR'S SIGNATURE <b>John Davidson</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 5760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 5121a

SHU-UN YANG, MD  
3353 OREGON  
BALTIMORE, MD 21204

Aug 8 '85

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21520

1. DECEDENT'S NAME (First, Middle, Last) <b>Ralph B. Harrison</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 5, 1991</b>				3. TIME OF DEATH <b>6:00 P. M.</b>			
4. SOCIAL SECURITY NUMBER <b>218 12 8144</b>		5. SEX <b>XX</b> <input type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/12/14</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3208 Chestnut Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Balto. City</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3208 Chestnut Avenue</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unknown</b>		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Preston Harrison</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Leona Coleman</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Michael Harrison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3526 Chestnut Avenue Balto. Md. 21211</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		DATE <b>8/6</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Burgee-Henss</b>				22. NAME AND ADDRESS OF FACILITY <b>Burgee-Henss Funeral Home 3631 Falls Road, Balto. Maryland 21211</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		28. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Betsy A. Fay M.D.</b>				29c. LICENSE NUMBER <b>D33220</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Betsy Fay 3730 Falls Road, Baltimore, Maryland 21211</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Earl Henderson</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>05</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>6:03 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-58-6862</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/5/51</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1917 Herbert Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1917 Herbert St.</b>				10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>US</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>none</b>				16b. KIND OF BUSINESS/INDUSTRY <b>--</b>				17. FATHER'S NAME (First, Middle, Last) <b>George Henderson</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriett hill Henderson</b>				19a. INFORMANT'S NAME (Type/Print) <b>Bernardette Wilson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1917 Herbert St. Balto., Md. 21217</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Me. Zion Cemetery</b>				20c. LOCATION — City or Town, State <b>Lansdowne, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Irvin Carroll</i>				22. NAME AND ADDRESS OF FACILITY <b>Irvin Carroll Funeral Home 1712-14 W. North Ave. Balto., Md. 21217</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Seizure Disorder</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Contusions of brain, remote</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year) <b>Unknown</b>				28b. TIME OF INJURY <b>Unknown</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Probable Fall</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Unknown</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Unknown</b>	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle, Jr. MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>	
29d. DATE SIGNED (Month, Day, Year) <b>08 06 1991</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Mario F. Golle, Jr. MD 111 Penn Street, Baltimore Maryland 21201</b>				31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OF MARYLAND: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>Edna Jones</b>		2. DATE OF DEATH MONTH <b>08</b> / DAY <b>06</b> / YEAR <b>1991</b>		3. TIME OF DEATH <b>6:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>118-14-1652</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>2-16-06</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>		9. COUNTY OF DEATH	
9a. FACILITY NAME (If not institution, give street and number) <b>MERCY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT					
10a. STATE <b>N.Y.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Jamaica</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>116-15 INWOOD</b>		10f. ZIP CODE <b>11434</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>2</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>NA</b> <b>College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>John Roberson</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Scippo Seitto</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Harris</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>116-15 Inwood/Jamaica, N.Y. 11434</b>		
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or <b>St. Raymond Cemetery</b>		20c. LOCATION — City or Town, State <b>Bronx, N.Y.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Synette K. Jones</b>			22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Subarachnoid hemorrhage DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <b>3</b> <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Kimberly G. Clarke MD</b>			29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kimberly G. Clarke 301 St Paul Place Baltimore MD</b>					
31. DATE FILED (Month, Day, Year) <b>8/6/91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Rendell</b>			

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COLONIAL

COLONIAL

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21523					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Joseph O. Kane				2. DATE OF DEATH MONTH 8 DAY 2 YEAR 91				3. TIME OF DEATH 6:00 A.M.					
4. SOCIAL SECURITY NUMBER 214-05-0601		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 6/14/16		8. BIRTHPLACE (State or Foreign Country) Md.			
9a. FACILITY NAME (If not institution, give street and number) (Home) 2609 Garrett Ave.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2649 Asquith St.				10f. ZIP CODE 21218				10g. CITIZEN OF WHAT COUNTRY? U.S.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 7/13/44-7/29/46		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: XX				14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Minister				16b. KIND OF BUSINESS/INDUSTRY Religious					
17. FATHER'S NAME (First, Middle, Last) Oscar Kane				18. MOTHER'S NAME (First, Middle, Maiden Surname) Laura Butler									
19a. INFORMANT'S NAME (Type/Print) Vermell Sheriff				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2605 Garrett Ave. Balto., Md. 21218									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Md. V.A. Garrison Forest 8/9		DATE 8/9		20c. LOCATION — City or Town, State Owings Mills, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Irvin Carroll</i>				22. NAME AND ADDRESS OF FACILITY Balto., Md. 21217-14 W. North Ave. Irvin Carroll Funeral Home									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  a. Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF):  b. Coronary Arteriosclerosis DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. NONE								Approximate Interval Between Onset and Death					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>A. Y. S. Rhee</i>		29c. LICENSE NUMBER DZ-366		29d. DATE SIGNED (Month, Day, Year) 8-5-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Alphonso Y.S. Rhee MD.D 449 E. 25th Street Balto Md. 21218													
31. DATE FILED (Month, Day, Year) 08-05-91 AUG 8				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									

BI 51253

DHMH-16 Rev 1/89

at 31254

ITEM:4 per FH  
G-678 8/16/91 cm

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21525

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES F. MULLAUER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 7, 1991</b>		3. TIME OF DEATH <b>11:05 A.M.</b>							
4. SOCIAL SECURITY NUMBER <b>215-07-2944-A</b> <b>218-03-0185</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 24 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>214 MARION AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>						
10a. STATE <b>MD.</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>214 MARION AVENUE</b>				10f. ZIP CODE <b>21236</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>						
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>N/A</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CUSTOMER SERVICE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BALTO. GAS &amp; ELECTRIC</b>									
17. FATHER'S NAME (First, Middle, Last) <b>FERDINAND MULLAUER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA (UNKNOWN)</b>									
19a. INFORMANT'S NAME (Type/Print) <b>DORIS MULLAUER (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>214 MARION AVENUE, BALTIMORE, MD. 21236</b>									
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREENMOUNT CREMATORY</b>		OATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eugene J. Lastner</i>				22. NAME AND ADDRESS OF FACILITY <b>SCHIMUNEK FUNERAL HOME INC.</b> <b>3331 Brehms Lane, Baltimore, Md. 21213</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <i>Metastatic Oat Cell CA Lung</i> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <i>Brain metastases.</i> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <i>Confusion 2010 Bm</i> <i>and DSCD.</i>								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Confusion 2010 Bm</i> <i>and DSCD.</i>								24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael A. Hyle M.D.</i>		29c. LICENSE NUMBER <b>D27693</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL A. HYLE, M.D.</b>				31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 31252



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SUE ANN MCCOY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 07 1991</b>		3. TIME OF DEATH <b>4:41 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>217-56-2614</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH Month Day Year <b>July 30, 1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Michigan</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3416 EAST FAIRMOUNT AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>XXXXXXXXXXXX</b>				10a. STATE <b>Maryland</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3416 E. Fairmount Avenue</b>	
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Assistant Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cafeteria</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Thomas DeVine, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sue Allenan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Robert M. McCoy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3416 E. Fairmount Avenue Baltimore, Maryland 21224</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 8/10/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Duck</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Seizure Disorder</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ b. _____ c. _____ d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Locke MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/07/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Locke MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 2125g

TO THE HOSPITAL OF ORIGIN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21527

1. DECEDENT'S NAME (First, Middle, Last) <b>John Owen Neighbours, Jr.</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:59 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215-14-5511</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>July 6, 1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Monkton</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1615 Corbett Road</b>		10f. ZIP CODE <b>21111</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Owen Neighbours, Sr.</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marie Clary</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Jane Neighbours</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1615 Corbett Rd., Monkton, Md. 21111</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. James Episcopal Ch. Cem.</b>		20c. LOCATION — City or Town, State <b>Monkton, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bryan W. Clary</b>		22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac tamponade</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Ruptured acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rebecca A. Ludwig</b>		29c. LICENSE NUMBER <b>D36226</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8-2-91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Rebecca A. Ludwig, M.D. GBMC 6701 North Charles Street, Balt. MD 21204</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

01 31251

91 21528

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERNARD Z. PODGORSKY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>21</b>		3. TIME OF DEATH <b>1:54 P</b> M	
4. SOCIAL SECURITY NUMBER <b>133-03-1167</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>May 12, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York City</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>8505 Springvale Drive</b>	
10f. ZIP CODE <b>20910</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Federal Police Officer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U. S. Government</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Morris Podgorsky</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Celia Podgorsky</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sheila Wolf</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4206 Garrett Park Road, Silver Spring, Maryland 20906</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mount Lebanon</b>		20c. LOCATION — City or Town, State <b>Hyattsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stottmeyer</b>				22. NAME AND ADDRESS OF FACILITY <b>D.M. STEIN HEBREW MEMORIAL FUNERAL HOME, INC. 232 CARROLL STREET, N.W., WASHINGTON, D.C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition) resulting in death → <b>Massive Brainstem Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DCA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Steven Burger</b>				29c. LICENSE NUMBER <b>D21931</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-4-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>DR. STEVEN BURGER - 401 Medical Park Dr. Silver Spring, Md</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. H. [Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL, CLINIC, OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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at 51250

91 21529

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SADIE B ROBERTS</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>03</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-29-3726</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>1</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7 29 90</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>503 McEldery Street #102</b>	
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Kennard S. Roberts, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henrietta McDonald</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Henrietta McDonald</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>503 McEldery Street #102 Baltimore, Maryland 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy Harris</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy Harris F/H 1701 McCulloh St. Baltimore, Md 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> (24 days) 7/10/91							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>HIV INFECTION</b> (9 mo) 10/91							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pulmonary Edema</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Regina M Simoneth MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Regina M Simoneth MD 600 N Wolfe St Balto Md 21205</i>							
31. DATE FILED (Month, Day, Year) <b>8/4/AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21530					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <b>Joseph Malachy Roche</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 2, 1991</b>				3. TIME OF DEATH <b>8:00 P M</b>					
4. SOCIAL SECURITY NUMBER <b>102-22-9522</b>		5. SEX <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0		6. AGE (In yrs. last birthday) <b>60</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 10 1930</b>		8. BIRTHPLACE (State or Foreign Country) <b>New York</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>227 Treherne Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Timonium</b>				9c. COUNTY OF DEATH <b>Baltimore</b>					
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0					
10e. STREET AND NUMBER <b>227 Treherne Rd.</b>				10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input checked="" type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0 IF YES, GIVE WAR OR DATES <b>Korean</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0 Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self Employed</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Printing Brokerage</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Patrick Aloysius Roche</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Mary Tynan</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Margaret L. Gahagan</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>417 North Rock Glen Rd., Balto., Md. 21229</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> 1 Burial <input type="checkbox"/> 2 Cremation <input type="checkbox"/> 3 Removal from State <input type="checkbox"/> 4 Donation <input type="checkbox"/> 5 Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens Timonium, Md.</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>		20d. DATE <b>8/7/91</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Martin D. Lawson</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCD</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> 1 Inpatient <input type="checkbox"/> 2 ER/Outpatient <input type="checkbox"/> 3 DOA <input type="checkbox"/> 4 OTHER: <input type="checkbox"/> 5 Nursing Home <input checked="" type="checkbox"/> 6 Residence <input type="checkbox"/> 7 Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> 1 Natural <input type="checkbox"/> 2 Accident <input type="checkbox"/> 3 Suicide <input type="checkbox"/> 4 Homicide <input type="checkbox"/> 5 Pending investigation <input type="checkbox"/> 6 Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> 1 <input checked="" type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4 <input type="checkbox"/> 5 <input type="checkbox"/> 6 <input type="checkbox"/> 7 <input type="checkbox"/> 8 <input type="checkbox"/> 9 <input type="checkbox"/> 0		28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one) <input type="checkbox"/> 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles F. O'Donnell MD</b>				29c. LICENSE NUMBER <b>D-09382</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell MD - 2304 Wonderview Rd. Timonium Md. 21093</b>				31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson Randall</b>					

at 21230

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21531

1. DECEDENT'S NAME (First, Middle, Last) <b>Francis Thompson</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:34 P M</b>							
4. SOCIAL SECURITY NUMBER <b>214-40-4902</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-2-06</b>		8. BIRTHPLACE (State or Foreign Country) <b>Wash. D.C.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Med. Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH					
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>2913 Baker St</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		15b. KIND OF BUSINESS/INDUSTRY <b>School Teacher</b>									
17. FATHER'S NAME (First, Middle, Last) <b>William D Dales</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Dyson</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Cesar Thompson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2913 Baker St. Balt. Md. 21216</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>Entombment</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Harbular Mem. Park, 77 Balto. Co. Md.</b>		DATE		20c. LOCATION — City or Town, State <b>Balto. Co. Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph L. Russ</b>				22. NAME AND ADDRESS OF FACILITY <b>Joseph L. Russ Funeral Home 2922 W. North Ave. Baltimore 21216</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic shock</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Osteomyelitis</b> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>exfoliative dermatitis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8/2/91</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael K. RO MC</b>		29c. LICENSE NUMBER <b>D39297</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/2/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL K RO MC</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>John R. ...</b>									



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21532

1. DECEDENT'S NAME (First, Middle, Last) <b>John MacFarlane Schmitt</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 3, 1991</b>		3. TIME OF DEATH HOUR MIN <b>11:17A</b>	
4. SOCIAL SECURITY NUMBER <b>066-32-4763</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 11 1940</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Med. Ctr.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Sparks</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>20 Cross Falls Way</b>			
10f. ZIP CODE <b>21152</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>62-64 Vietnam</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Dir. of Real Estate - Rite Aid Corp.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Retail Pharmacies</b>			
17. FATHER'S NAME (First, Middle, Last) <b>William A Schmitt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Elizabeth Marcellus</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Margaret D. Schmitt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>20 Cross Falls Way, Sparks, Md. 21152</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Martin D. Lawson</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Md.</b>			
23. PART I. Enter the illness, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCD</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles F. O'Donnell MD</b>				29c. LICENSE NUMBER <b>09383</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/3/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell (MD) 2304 Timonium Rd</b>							
31. DATE FILLED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

01 51235

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH91 21533  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ambrose Gerard Sauer, Jr.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:09 P M</b>							
4. SOCIAL SECURITY NUMBER <b>216 01 4337</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10 1 13</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Greater Baltimore Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>							
10a. STATE <b>Md</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Timonium</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>107 Longdale Rd</b>				10f. ZIP CODE <b>21093</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Superintendent of Labor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Maritime</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Ambrose Gerard Sauer, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Charlotte Pahr</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Helen Marie Sauer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 Longdale Rd., Timonium, Md. 21093</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Memorial Gardens Timonium, Md.</b>		DATE		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lowell M. Lemmon</b>		22. NAME AND ADDRESS OF FACILITY <b>Leamon-Mitchell-Wiedefeld Timonium, Maryland</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Acute myocardial infarction</b> <b>Acute Pulmonary edema</b> <b>Coronary Artery Disease</b>								Approximate interval Between Onset and Death <b>64y.</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Squamous cell Carcinoma (L)</b> <b>Stomach</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		27a. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY <b>M</b>		27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27d. DESCRIBE HOW INJURY OCCURRED	
28a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		28b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald Woodward MD</b>		28c. LICENSE NUMBER <b>D1174</b>		28d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald O. Woodward, MD - 2 Green Meadow Dr. Timonium</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									

Handwritten scribbles or marks.

(M)

Handwritten text at the bottom of the page.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21534			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <u>Elizabeth (Elizabeth) A. SPARKS (Sparks)</u>				2. DATE OF DEATH MONTH <u>August</u> DAY <u>7</u> YEAR <u>1991</u>				3. TIME OF DEATH <u>6:32 A M</u>			
4. SOCIAL SECURITY NUMBER <u>217-26-3822</u>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <u>85</u> YRS.	IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>	IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>	7. DATE OF BIRTH (Month, Day, Year) <u>5-1-1906</u>		8. BIRTHPLACE (State or Foreign Country) <u>Balto., Md.</u>			
9a. FACILITY NAME (If not Institution, give street and number) <u>FRanklin Square Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH <u>Baltimore</u>			
RESIDENCE OF DECEDENT											
10a. STATE <u>MD.</u>		10b. COUNTY <u>Baltimore</u>		10c. CITY, TOWN OR LOCATION <u>Baltimore</u>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <u>7436 Kenlea Avenue</u>				10f. ZIP CODE <u>21206</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>  </u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <u>  </u>				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <u>Elementary/Secondary (8-12)</u> <u>7th Grade</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Home Maker</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Home</u>			
17. FATHER'S NAME (First, Middle, Last) <u>August Haetler</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Anna Schmidt</u>							
19a. INFORMANT'S NAME (Type/Print) <u>James Hand Sparks</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>7436 Kenlea Avenue Baltimore, Md.-21206</u>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Greenmount Cemetery</u>		20c. LOCATION — City or Town, State <u>Baltimore, Md.</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Katherine M. Murphy</u>				22. NAME AND ADDRESS OF FACILITY <u>John C. Miller, Inc. 6415 BELair Road Baltimore, MD.-21206</u>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Decompensated Congestive Heart Failure</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Anasarca</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Acute Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Myocardial Infarction</u>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <u>Hypertension</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u>							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <u>  </u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <u>Ram Nassar MD</u>						29c. LICENSE NUMBER <u>N/A</u>		29d. DATE SIGNED (Month, Day, Year) <u>August 7, 1991</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>R. Nassar, M.D. 9000 Franklin Square Drive Baltimore, MD 21237</u>											
31. DATE FILED (Month, Day, Year) <u>AUG 8 1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson Rouse</u>							

at 31234

Items 25,27,28a-f, per MEO, G-690, 8/13/92 gn

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21535

1. DECEDENT'S NAME (First, Middle, Last) <b>(MAYONNEY TALIFEARRO)</b>		2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 6, 1991</b>		3. TIME OF DEATH <b>7:55a.m. M</b>	
4. SOCIAL SECURITY NUMBER <b>214-16-5276</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>520 POPLAR GROVE ST.</b>		10f. ZIP CODE <b>21223</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>SOCIAL SECURITY</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SADIE WMS.</b>		19a. INFORMANT'S NAME (Type/Print) <b>GEORGE TALIFEARRO</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>520 POPLAR GROVE STREET/BALTO. MD 21223</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEM. PK.</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys Wanes</b>		22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heat Stroke</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death <b>2 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Renal Failure</b>					24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7/23/91</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Excessive environmental heat</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>House</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>520 Poplar Grove Street, Baltimore, MD</b>			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Patty Lee M.D.</b>		29c. LICENSE NUMBER <b>J5083</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Patty Lee MD Johns Hopkins Hospital Baltimore, MD</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
7-251-49-85 000 1  
TALIFEARRO, MAYONNEY  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21536

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret Elizabeth Cromwell Thomas</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 5 1991</b>		3. TIME OF DEATH <b>4:30 A. M</b>	
4. SOCIAL SECURITY NUMBER <b>215-32-2180</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 31 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>17304 Big Falls Rd.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Monkton</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Monkton</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>17304 Big Falls Rd.</b>	
10f. ZIP CODE <b>21111</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Horace Elmer Cromwell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Grace Lohye</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jane E. Jones</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>17304 Big Falls Rd; Monkton, Md. 21111</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Luke's A.M.E. Church</b>		20c. LOCATION — City or Town, State <b>Hereford, Md.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Martin D. Lawson</b>	
22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Metastatic cancer of breast</b> DUE TO (OR AS A CONSEQUENCE OF): <b>and ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cancer of colon</b> <b>NIDDM</b>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>NA</b>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard C. Haberstat, M.D.</b>				29c. LICENSE NUMBER <b>018822</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Richard C. Haberstat, M.D. 120 Sister Pierre Dr., Towson, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


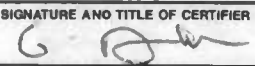
at 5123e

at 5123e

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>RAYMOND FRANCIS TANNER (aka Oliver W. Tanner)</b>								2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>91</b>				3. TIME OF DEATH <b>10:54 A M</b>			
4. SOCIAL SECURITY NUMBER <b>224-03-3563</b>				5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH Month, Day, Year <b>4-5-1916</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>ROSSVILLE</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>MARYLAND</b>								10b. COUNTY <b>BALTIMORE CITY</b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO								10e. STREET AND NUMBER <b>6500 COLGATE AVENUE</b>				10f. ZIP CODE <b>21222</b>			
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>								11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:								14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>N/A</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>								16b. KIND OF BUSINESS/INDUSTRY <b>BETHLEHEM STEEL CORP</b>				17. FATHER'S NAME (First, Middle, Last) <b>OLIVER WINFIELD TANNER</b>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELLA BLANCHE BEAHM</b>								19a. INFORMANT'S NAME (Type/Print) <b>BRENDA KELLY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>535 CRESTPARK DRIVE GLEN BURNIE, MARYLAND 21067</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify):								20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>MEADOWRIDGE MEMORIAL 8-8-1991</b>				20c. LOCATION — City or Town, State <b>DORSEY, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY <b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222</b>				23. PART I. Enter the diseases, or complications they caused the death. Do not enter the mode of dying, such as cardiac arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>  Due to (or as a consequence of): <b>Massive Myocardial Infarction</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Insufficiency, Pulmonary Edema, Hypoxia, Atrioventricular nodal disease</b>			
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)								27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>8-8-1991</b>			
28b. TIME OF INJURY <b>M</b>								28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER			
29d. DATE SIGNED (Month, Day, Year) <b>8-8-1991</b>								30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Gilbert Desmangles, MD 9000 Franklin Sq. Dr., Balto., MD 21237</b>				31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>			

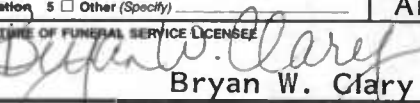

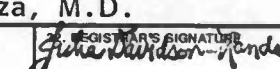
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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anne Lessie Mitchell Vaughan</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 5 1991</b>		3. TIME OF DEATH M							
4. SOCIAL SECURITY NUMBER <b>256-90-2563</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>81</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>March 10 1910</b>		8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>14519 Bonnie View Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Sparks</b>				9c. COUNTY OF DEATH <b>Baltimore</b>					
RESIDENCE OF DECEDENT													
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Sparks</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>14519 Bonnie View Road</b>				10f. ZIP CODE <b>21152</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Thomas W. Mitchell</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Henrietta Cockman</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Peggy V. Hart</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14519 Bonnie View Rd., Sparks, Md. 21152</b>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington Memorial Park</b>				DATE		20c. LOCATION — City or Town, State <b>Atlanta, Georgia</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>Bryan W. Clary</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cor Pulmonale Heart</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>AS 1st</b> b. <b></b> c. <b></b> d. <b></b>										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Alan J. Baldanza, M.D.</b>						29c. LICENSE NUMBER <b>D19166</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alan J. Baldanza, M.D. 10629 York Road, Cockeysville, Md. 21030</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b> REGISTRAR'S SIGNATURE 													

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLARA L. WALKER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 05 1991</b>		3. TIME OF DEATH <b>7:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-10-5382n</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-10-25</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1038 N. Eden ST</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Mexican</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Louis MURDOCK</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY Drumming</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CARROLL CANNINGTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1038 N. Eden ST BALTO MD 21205</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial</b>		20c. LOCATION — City or Town, State <b>BALTO. MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC LYMPHOMA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>1 YR.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Katrina Amsharov MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K ARMSTRONG MD, 600 N. WOLFE ST., BALTO MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transfer permit. Pages 1, 2, 3 should be filed with the funeral director.

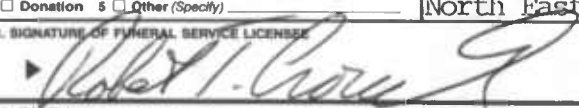
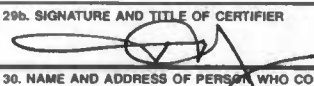

IMPORTANT: If death was due to injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Margaret Irene Aro</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:05 A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-01-1052</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-2-19</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>16 Indian Rd.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>North East</b>	
9c. COUNTY OF DEATH <b>Cecil</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>	
10c. CITY, TOWN OR LOCATION <b>North East,</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>16 Indian Road</b>	
10f. ZIP CODE <b>21901</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Albert Streaker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Irene Violet Reynolds</b>			
19a. INFORMANT'S NAME (Type/Print) <b>George Gilbert Aro</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>16 Indian Road North East, Maryland 21901</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>North East Methodist Cemetery</b>		20c. LOCATION — City or Town, State <b>North East, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Crouch Funeral Home 127 South Main St. North East, MD 21901</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. END Stage Cardiac disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Other (Specify)				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D32395</b>		29d. DATE SIGNED (Month, Day, Year) <b>JUL 29 '91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>3 Mauldin Avenue North East MD. 21901</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Raymond Aro</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 27, 1991</b>		3. TIME OF DEATH M <b>2130</b>	
4. SOCIAL SECURITY NUMBER <b>221-42-7327</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 5, 1953</b> MD	
9a. FACILITY NAME (If not institution, give street and number) <b>Union Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>		9c. COUNTY OF DEATH <b>Cecil</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Elkton</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1194 Nottingham Rd.</b>				10f. ZIP CODE <b>21921</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sponsor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>W.L. Gore &amp; Assoc.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Edward S. Aro, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Catherine Baker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda M. Aro</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1194 Nottingham Rd, Elkton, MD 21921</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gilpin Manor Mem.Park</b>		20c. LOCATION — City or Town, State <b>Elkton, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward M. Aro</i>				22. NAME AND ADDRESS OF FACILITY <b>259 E. Main St. Elkton, MD 21921</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>b. acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. Coronary Artery Disease (atherosclerotic)</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Jui Zhi Hsu MD</b>				29c. LICENSE NUMBER <b>D04823</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Jui Chih Hsu, MD 223 West Main St. Elkton MD 21921</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>Johie Davidson-Hendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.







1. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being investigated. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the subjects involved, and the procedures used to collect and analyze the data. The third part of the report is a description of the results of the study. This includes a summary of the findings and a discussion of their implications. The fourth part of the report is a conclusion and a list of references.

2. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being investigated. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the subjects involved, and the procedures used to collect and analyze the data. The third part of the report is a description of the results of the study. This includes a summary of the findings and a discussion of their implications. The fourth part of the report is a conclusion and a list of references.

3. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being investigated. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the subjects involved, and the procedures used to collect and analyze the data. The third part of the report is a description of the results of the study. This includes a summary of the findings and a discussion of their implications. The fourth part of the report is a conclusion and a list of references.

4. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being investigated. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the subjects involved, and the procedures used to collect and analyze the data. The third part of the report is a description of the results of the study. This includes a summary of the findings and a discussion of their implications. The fourth part of the report is a conclusion and a list of references.

5. The first part of the report is a general description of the project and its objectives. It includes a brief history of the project and a statement of the problem being investigated. The second part of the report is a description of the methods used in the study. This includes a description of the experimental design, the subjects involved, and the procedures used to collect and analyze the data. The third part of the report is a description of the results of the study. This includes a summary of the findings and a discussion of their implications. The fourth part of the report is a conclusion and a list of references.

ITEMS: 7, 8 per FH  
G-679 9/6/91 cm

91 21543

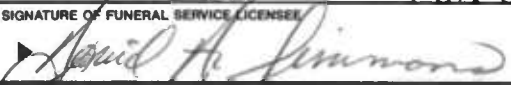
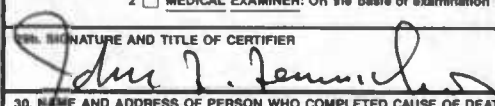
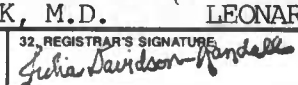
1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>CELESTINE MARGARET ADAMS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 5, 1991</b>		3. TIME OF DEATH <b>9:00 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-44-3052</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 1, 1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>AT HOME - RT. 249, PINEY POINT</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>PINEY POINT</b>		9c. COUNTY OF DEATH <b>ST. MARY'S CO.</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>		10c. CITY, TOWN OR LOCATION <b>PINEY POINT</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. BOX 236</b>				10f. ZIP CODE <b>20674</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>OFFICE MANAGER</b>		16. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>DANIEL KINSLEY ALBRIGHT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET LINK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHARLES REGINALD ADAMS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 236, PINEY POINT, MARYLAND 20674</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. GEORGE EPISCOPAL</b>		DATE <b>8/08/91</b>		20c. LOCATION — City or Town, State <b>VALLEY LEE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Aspiration</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Alzheimer's</b> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Decubitus ulcers</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D01380</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN F. FENWICK, M.D. LEONARDTOWN, MARYLAND 20650</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 07 '91</b>		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21544

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MARY REGINA ANDERSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 31, 1991</b>		3. TIME OF DEATH <b>8:54 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-24-0445</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 29, 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>		10. COUNTY OF DEATH <b>St. Mary's</b>	
11. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Hospital</b>				12. RESIDENCE OF DECEASED <b>MARYLAND ST. MARY'S MECHANICSVILLE</b>		13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
14. STREET AND NUMBER <b>4495 THOMPSON CORNER ROAD</b>				15. ZIP CODE <b>20659</b>		16. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
21. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th GRADE</b>		22. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		23. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
24. FATHER'S NAME (First, Middle, Last) <b>NINIAN PINKNEY BARBER</b>				25. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PAULINE REGINA ADAMS</b>			
26. INFORMANT'S NAME (Type/Print) <b>JOSEPH ALBERT ANDERSON</b>				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4495 THOMPSON CORNER RD., MECHANICSVILLE, MD. 20659</b>			
28. MANNER OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHARLES MEMORIAL GARDENS 8/3/91</b>		30. LOCATION — City or Town, State <b>LEONARDTOWN, MD.</b>			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardner</i>				32. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<b>a. Diffuse Infiltration, Thoracic-Abdominal</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>4 mos</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		<b>b. Non-Hodgkin's Lymphoma, Large Cell, B-cell type</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>6+ mos</b>	
c.		DUE TO (OR AS A CONSEQUENCE OF):					
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				25. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
26. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		27. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
28. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		29. DATE OF INJURY (Month, Day, Year)		30. TIME OF INJURY <b>M</b>		31. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
32. DESCRIBE HOW INJURY OCCURRED		33. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		34. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
30. SIGNATURE AND TITLE OF CERTIFIER <i>John W. Roache</i>				31. LICENSE NUMBER <b>D15027</b>		32. DATE SIGNED (Month, Day, Year) <b>1 Aug 91</b>	
33. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John W. Roache, M.D. MECHANICSVILLE, MARYLAND 20659</b>							
34. DATE FILED (Month, Day, Year) <b>AUG 02 '91</b>		35. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

at 31244

1. The first part of the paper is devoted to the study of the properties of the function  $f(x)$  defined by the equation  $f(x) = \int_0^x f(t) dt$ . It is shown that  $f(x)$  is a constant function, and its value is determined by the initial condition  $f(0)$ .

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Item:5, per F.H. 11/12/91

1. FOR  
STATE G-681 reb  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDNA M. APPEL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 22, 1991</b>		3. TIME OF DEATH M <b>2:00P</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-7207</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-17-1899</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD</b>				9. BIRTHPLACE (State or Foreign Country) <b>Cumberland</b>		10. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>306 Pulaski Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6</b> Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Grocery Store</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Henry A. Appel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary (Stuckenous)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert L. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>225 Pear St., Cumberland, Md. 21502</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Luke's Lutheran Cem 7/24 Cumberland</b>		20c. LOCATION — City or Town, State <b>Cumberland</b>		20d. LOCATION — City or Town, State <b>Cumberland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William L. Kight</i>				22. NAME AND ADDRESS OF FACILITY <b>Kight Funeral Home 309 Decatur St., Cumberland, Md. 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Ascending Cholangitis</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Barrera</i>				29c. LICENSE NUMBER <b>D 14865</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-23-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Barrera Memorial Hospital Medical Building, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>				32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Arnetta Ammons</b> ARNETA B. AMMONS				2. DATE OF DEATH MONTH <b>7</b> DAY <b>25</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12 N</b>	
4. SOCIAL SECURITY NUMBER <b>229 286 476</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2 6 1926</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>130 HEARNE RD. APT 407</b>				10f. ZIP CODE <b>21401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RECEPTIONIST</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JEFFERSON MILES BEARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ERNIE SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES H. AMMONS, III</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>130 HEARNE RD. APT. 407 ANNAPOLIS, MD. 21401</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERAN CEME. 7-30-91</b>		20c. LOCATION — City or Town, State <b>CHELTANHAM, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Larry H. Reese</b>				22. NAME AND ADDRESS OF FACILITY <b>821 WEST ST ANNAPOLIS, MD. 21401</b> <b>REESE &amp; SONS MORTUARY, P.A.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Respiratory Failure</b> <b>Due to (or as a consequence of):</b> <b>Lung Cancer</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald C. Roane, MD.</b>				29c. LICENSE NUMBER <b>510698</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald C. Roane, MD. 1616 Forest Drive Annapolis 21403</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>		32. REGISTRAR'S SIGNATURE <b>Gelia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Emma Jean Buckland</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0001 A</b>					
4. SOCIAL SECURITY NUMBER <b>232-60-6188</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>62</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>4-30-29</b>	8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Union Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>			9c. COUNTY OF DEATH <b>Cecil</b>				
RESIDENCE OF DECEDENT											
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>North East</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>63 Nazerene Camp Road</b>				10f. ZIP CODE <b>21901</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>n/a</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Norval E. Willey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Sears</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Paul T. Buckland</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>63 Nazerene Camp Road North East, MD 21901</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Union Cemetery</b>				20c. LOCATION — City or Town, State <b>Elkton, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Crouch Funeral Home</b> <b>127 S. Main St. North East, MD 21901</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal failure, CHF, (Sepsis possible)</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes mellitus, Hxw. Ac MI.</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>D-26183</b>			29d. DATE SIGNED (Month, Day, Year) <b>7-29-91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>301 Main St North East, MD 21901</b>											
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>									

**BALTIMORE, MARYLAND 21203-3146**

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

21 51243

91 21548

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) James T. Brown, Sr.				2. DATE OF DEATH MONTH DAY YEAR July 26 1991				3. TIME OF DEATH 6:10 P M					
4. SOCIAL SECURITY NUMBER 369-28-2288		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		8. AGE (In yrs. last birthday) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 29, 1924		8. BIRTHPLACE (State or Foreign Country) Kentucky	
9a. FACILITY NAME (If not institution, give street and number) Residence: 102 Fairway Court						9b. CITY, TOWN OR LOCATION OF DEATH Havre de Grace				9c. COUNTY OF DEATH Harford			
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Havre de Grace				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 102 Fairway Court						10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 1942 - 1945		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) Nine Years -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Fire Fighter				16b. KIND OF BUSINESS/INDUSTRY V.A. Medical Center Perry Point, Maryland					
17. FATHER'S NAME (First, Middle, Last) Thomas J. Brown						18. MOTHER'S NAME (First, Middle, Maiden Surname) Dulcenia Miller							
19a. INFORMANT'S NAME (Type/Print) Ellen P. Brown						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 102 Fairway Court, Havre de Grace, Maryland 21078							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Harford Memorial Gardens 7/31/91				20c. LOCATION — City or Town, State Aberdeen, Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas M. Patterson Sr.</i>						22. NAME AND ADDRESS OF FACILITY Lee A. Patterson & Son Funeral Home Perryville, Maryland 21903							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>ADENOCARCINOMA of LUNG</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. _____										Approximate Interval Between Onset and Death 18 MON			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joan P. Edwards</i>				29c. LICENSE NUMBER D31775		29d. DATE SIGNED (Month, Day, Year) 7/29/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Joan P. Edwards, M.D., 2112 Bel Air Road, Fallston, Maryland 21047													
31. DATE FILED (Month, Day, Year) JUL 30 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

81 51248

81 51248

91 21549

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Henry E. Baker</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>20</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10<sup>04</sup> A<sup>M</sup></b>		
4. SOCIAL SECURITY NUMBER <b>384-05-2922</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/24/17</b>		8. BIRTHPLACE (State or Foreign Country) <b>Chicago Il.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Holy Cross Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>		9c. COUNTY OF DEATH <b>Montgomery</b>		
10a. STATE <b>D. C.</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Washington</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1700 Redwood Terrace N. W.</b>				10f. ZIP CODE <b>20012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>2 yrs</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mail clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Federal government</b>				
17. FATHER'S NAME (First, Middle, Last) <b>James Baker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carlelia Baker</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Jerdia S. Baker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>POST OFFICE BOX 55524 Washington DC 20011</b>				
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harper's Funeral Home 2-24</b>		DATE <b>7/20/91</b>		20c. LOCATION — City or Town, State <b>Kalamazoo, MI</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>J. P. Marshall</b>				22. NAME AND ADDRESS OF FACILITY <b>Marshall's Funeral Home, Inc. 4217 9th Street, NW Washington, DC 20011</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Renal Failure</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO								
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter B. Sherer MD</b>				29c. LICENSE NUMBER <b>D 21910</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/20/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter B. Sherer MD 3947 Ferrara Pr. Wheaton MD 20906</b>								
31. DATE FILED (Month, Day, Year) <b>JUL 23 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 1219



91 21550

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gladys M. Butler</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 22 1991</b>		3. TIME OF DEATH <b>12:02 AM</b>	
4. SOCIAL SECURITY NUMBER <b>110 16 9555</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 18 1901</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Crofton Convalescent Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Crofton</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2576 Twin Landing Cove</b>			
10f. ZIP CODE <b>21401</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>No</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>NO</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>-----</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Music Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N.Y. State Schools</b>	
17. FATHER'S NAME (First, Middle, Last) <b>David Boag</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Arlene Whiteman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy B. Sandleman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2576 Twin Landing Cove Annapolis Maryland 21401</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>-----</b>				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory</b>		20c. LOCATION — City or Town, State <b>Alexandria Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert E. Evans Pres.</b>				22. NAME AND ADDRESS OF FACILITY <b>Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Alzheimer's Disease</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>-----</b>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 8 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James Rhodes MD</b>				29c. LICENSE NUMBER <b>022028</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-22-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Paul S. Rhodes MD 1667 Crofton Center Suite 1 Crofton Maryland 21114</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21551

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Dorothy A. Beall				2. DATE OF DEATH MONTH DAY YEAR July 20 1991		3. TIME OF DEATH 5:30 p.m.	
4. SOCIAL SECURITY NUMBER 217 18 2328		6. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) Dec. 31 1923	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) Physicians Memorial Hospital		9b. CITY, TOWN OR LOCATION OF DEATH LaPlata	
9c. COUNTY OF DEATH Charles				10a. STATE Maryland		10b. COUNTY Charles	
10c. CITY, TOWN OR LOCATION White Plains				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER P.O. Box 572	
10f. ZIP CODE 20695				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES No				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: No		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (14 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) James F. McClelland				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susan Garner			
19a. INFORMANT'S NAME (Type/Print) Ernest V. Beall, Jr.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 329D Bulls Gap, Tenn. 37711			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) -----				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Fort Lincoln Cemetery		20c. LOCATION — City or Town, State Brentwood Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans, Pres.				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Rd. Bowie Maryland 20715			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cerebrovascular accident Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hypertension Atherosclerosis							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Anemia, Diabetes mellitus, Chronic obstructive pulmonary disease, peptic ulcer disease, renal stones							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) -----			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Paul E. Pritchett, M.D.				29c. LICENSE NUMBER D-08370		29d. DATE SIGNED (Month, Day, Year) 7/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul E. Pritchett, M.D. PO.Box1317 118 LaGrange Ave. LaPlata, MD. 20646							
31. DATE FILED (Month, Day, Year) JUL 25 '91				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21552

1. DECEDENT'S NAME (First, Middle, Last) <b>ALLEN J. BRICE</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0900</b> M	
4. SOCIAL SECURITY NUMBER <b>225 24 3596</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09 25 23</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SHADY GROVE ADVENTIST HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ROCKVILLE</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>	
10c. CITY, TOWN OR LOCATION <b>UPPER MARLBORO</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4808 WOODFORD LANE</b>	
10f. ZIP CODE <b>20772</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1945-1946</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MESSENGER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PRINTING COMPANY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ERWIN BRICE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESTELL BUCK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MICHELLE BRICE (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4808 Woodford Lane, Upper Marlboro, MD 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b>7723791</b>				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MARYLAND VETERANS CEMETERY</b>		20c. LOCATION — City or Town, State <b>CHELTENHAM, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Alex S. Pope Jr</b> M859				22. NAME AND ADDRESS OF FACILITY <b>ALEXANDER S. POPE FUNERAL HOME</b> <b>2617 Pennsylvania Avenue, SE DC 20020</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYOCARDIAL INFARCTION</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>7-18-91</b>			
28b. TIME OF INJURY <b>A</b> M				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURED <b>DID NOT WAKE UP</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>443 W. DARNLEY AVE GAITHERSBURG MD</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Francis C. Meyer</b>				29c. LICENSE NUMBER <b>007094</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-18-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS C MEYER 8200 Wisconsin Ave Bethesda MD 20814</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 22 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

91 51225

91 21553

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Richard Rogers Barnes</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>18</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>577-44-8032</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-15-35</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>5126 Marx Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>West River</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>West River</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5126 Marx Drive</b>				10f. ZIP CODE <b>20778</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Vice-Pres. and Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>The Lewis Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Richard T. Barnes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Bannon</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan E. Barnes</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a-10f.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Resurrection Cemetery</b>		20c. LOCATION — City or Town, State <b>Clinton, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James D. Bates</i>				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>18 yrs</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY <b>M</b>		26c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		26d. DESCRIBE HOW INJURY OCCURRED		26e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Smith</i>				29c. LICENSE NUMBER <b>11506</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/18/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


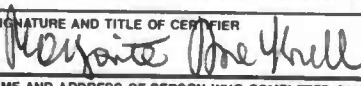
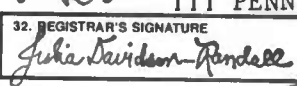
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

81 51223



1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT REYNOLDS BUZARD</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-60-2576</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/15/53</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pittsburg, PA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>5200 47TH AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Edmonston</b>	
9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Edmonston</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5200 47th Avenue</b>	
10f. ZIP CODE <b>20781</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11th</b> College (1-4 or 5+) <b>-----</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Renolds Clint Buzard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Mary Gloeckner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Buzard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9501 Midland Turn, Upper Marlboro, Maryland 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington National Cem. 7/25/91</b>			
20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE 			
22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEIZURE DISORDER</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>7/25/91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>			
29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARY ANN B. VORN 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>			
31. DATE FILED (Month, Day, Year) <b>JUL 26 91</b>				32. REGISTRAR'S SIGNATURE 			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

(3)

01 51226

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARRIE REBECCA BISCOE				2. DATE OF DEATH MONTH DAY YEAR 08 04 91		3. TIME OF DEATH 9:40 P M	
4. SOCIAL SECURITY NUMBER 216-05-0385		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) OCT. 11, 1901	
9a. FACILITY NAME (If not institution, give street and number) 2436 CHRISTIAN STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE CITY		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2436 CHRISTIAN STREET				10f. ZIP CODE 21223		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 8TH. GRADE				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOME	
17. FATHER'S NAME (First, Middle, Last) JAMES LUTHER PEGG				18. MOTHER'S NAME (First, Middle, Maiden Surname) SARAH ELLEN PURCELL			
19a. INFORMANT'S NAME (Type/Print) EILEEN CLEMENTS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 101, LEXINGTON PARK, MARYLAND 20653			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) EBENEZER CEMETERY		20c. DATE 08/08/91		20d. LOCATION — City or Town, State LEXINGTON PARK, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David A. Simmons</i>				22. NAME AND ADDRESS OF FACILITY MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>atherosclerotic Cardiovascular Disease</i>							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John J. Penetum</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08/05/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERNEST J. PENETUM 111 PENN STREET, BALTIMORE, MARYLAND 21201							
31. DATE FILED (Month, Day, Year) AUG 07 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

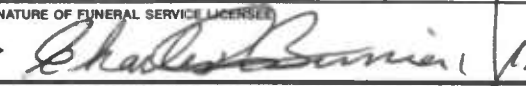


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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) William David Bryant				2. DATE OF DEATH MONTH DAY YEAR July 26, 1991		3. TIME OF DEATH 5:00 A. M	
4. SOCIAL SECURITY NUMBER 214-40-9493		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 48 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 27, 1943	
8. BIRTHPLACE (State or Foreign Country) Maryland		9a. FACILITY NAME (If not institution, give street and number) 15850 Old Frederick Road		9b. CITY, TOWN OR LOCATION OF DEATH Woodbine		9c. COUNTY OF DEATH Howard	
10a. STATE Maryland				10b. COUNTY Howard		10c. CITY, TOWN OR LOCATION Woodbine	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 15850 Old Frederick Road		10f. ZIP CODE 21797	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 9 yrs. College (1-4 or 5+) none	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Construction				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) Dewey J. Bryant	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Berdie Wolverton				19a. INFORMANT'S NAME (Type/Print) Berdie M. Bryant		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 15850 Old Frederick Rd. Woodbine, Md. 21797	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) McKendree Cemetery		20c. LOCATION — City or Town, State Howard Co., Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY Burrier Funeral Home Winfield, Maryland 21784		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Chronic Alcoholism DUE TO (OR AS A CONSEQUENCE OF): b. Seizure Disorder DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. No pancreas surgery				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> 4 <input type="checkbox"/> Homicide	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER  Deputy Asst Medical Examiner		29c. LICENSE NUMBER D 3473	
29d. DATE SIGNED (Month, Day, Year) 7/26/91				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PATRYCE A. TOYE, MD 4505 HENLOCK CONE WAY, ELICOTT CITY MD 21042		31. DATE FILED (Month, Day, Year) JUL 30 '91	
32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

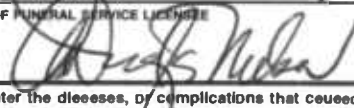

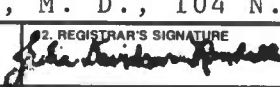
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21557

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Minnie M. Bertrand				2. DATE OF DEATH MONTH DAY YEAR 7 - 23 - 1991		3. TIME OF DEATH 6:50 AM M	
4. SOCIAL SECURITY NUMBER 221-18-2579		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 95 YRS.	7. DATE OF BIRTH (Month, Day, Year) Feb. 12, 1896		8. BIRTHPLACE (State or Foreign Country) Frankford, DE	
9a. FACILITY NAME (If not institution, give street and number) 6032 Whiton Road				9b. CITY, TOWN OR LOCATION OF DEATH Snow Hill, Maryland		9c. COUNTY OF DEATH Worcester	
10a. STATE Delaware		10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Frankford (Roxana)		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER RD# 2 Box 93				10f. ZIP CODE 19945		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY None			
17. FATHER'S NAME (First, Middle, Last) Ezekiel Lynch				18. MOTHER'S NAME (First, Middle, Maiden Surname) Carrie Lynch (Maiden name Lynch)			
19a. INFORMANT'S NAME (Type/Print) Wilda Clarke				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6032 Whiton Rd., Snow Hill, Maryland 21863			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Mariner's Bethel Cemetery		20c. LOCATION — City or Town, State Ocean View, Delaware			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY Melson Funeral Services, Ltd. Frankford, Delaware 19945					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Myocardial Insufficiency</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Mitral regurgitation</u> b. <u>Calcified mitral valve</u> DUE TO (OR AS A CONSEQUENCE OF): <u>Malnutrition</u> c. <u>Chronic cholecystitis &amp; cholelithiasis</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death 1 week ? yrs 6 months unknown
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Abnormal liver function</u> <u>Atrial Fibrillation</u> <u>osteoporosis</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <u>daughter's home</u>					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER D05865		29d. DATE SIGNED (Month, Day, Year) 7-23-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert C. LaMar, M. D., 104 N. Bay Street, Snow Hill, Maryland 21863							
31. DATE FILED (Month, Day, Year) JUL 30 '91		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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8/27/58

8/27/58



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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Grisabeth Brown</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 22, 1991</b>		3. TIME OF DEATH <b>0120</b> M	
4. SOCIAL SECURITY NUMBER <b>221-01-8496</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/29/13</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Sussex</b>		10c. CITY, TOWN OR LOCATION <b>Delmar</b>	
10d. INSIDE-CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>Rt 2 Bx 184</b>		10f. ZIP CODE <b>19940</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Blk.</b>		15. DECEDENT'S EDUCATION (Specify <u>only</u> highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck King</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Hasting Inc.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Walter Brown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mildred Brown</b>				19b. MAILING ADDRESS (Street and Number, or Rural Route Number, City or Town, State, Zip Code) <b>Rt 2 Bx 184 Delmar, Del 19940</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion Church Cemetery 7-26-91</b>		20c. LOCATION — City or Town, State <b>Salisbury, Md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bussell</b>				22. NAME AND ADDRESS OF FACILITY <b>Travis Funeral Home P.O. Box 1574 Salisbury, Md 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Primary liver carcinoma</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Rodney A. Wernich, M.D.</b>				29c. LICENSE NUMBER <b>D15384</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-25-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RODNEY A. WERNICH 100 POWER ST. SALISBURY Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson</b>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACK RICHARD</b>				2. DATE OF DEATH MONTH <u>July</u> DAY <u>26</u> YEAR <u>1991</u>				3. TIME OF DEATH <u>0700</u> M	
4. SOCIAL SECURITY NUMBER <u>212-78-4776</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>32</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>7-10-59</u>		8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>	
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>HOLLY CENTER SNOW HILL ROAD</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b>NONE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>NONE</b>			16b. KIND OF BUSINESS/INDUSTRY <b>NONE</b>		
17. FATHER'S NAME (First, Middle, Last) <b>JACK L. BAUGHMAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BETTY JEAN FRADY KIRBY</b>					
19a. INFORMANT'S NAME (Type/Print) <b>BETTY JEAN KIRBY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1 BOX 387 NEBO, NC. 28761</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		DATE		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John H. Halbury</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL ROAD SALISBURY, MD 21801</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Respiratory Arrest</b> <b>Severely mental Retardation</b> <b>Seizure Disorder</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Fever of unknown origin</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severely mental Retardation</b> <b>Seizure Disorder</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> Hospital: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Atkins</i>				29c. LICENSE NUMBER <b>D39813</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael Atkins 1104 Heathway Dr. Salisbury, Md.</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 29 91</b>				32. REGISTRAR'S SIGNATURE <i>John H. Halbury</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 21560

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM JOHN BULL</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>19</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>10:45 AM</b>			
4. SOCIAL SECURITY NUMBER <b>212-16-7646</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-30-1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Rome PA.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>At his home RT.1 Box 132</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Parsonsborg</b>			9c. COUNTY OF DEATH <b>Wicomico</b>		
10a. STATE <b>MD.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Parsonsborg</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>RT.1 Box 132</b>				10f. ZIP CODE <b>21849</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farmer</b>		15c. KIND OF BUSINESS/INDUSTRY <b>Own Farmer</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Omar Bull</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Marian Kilmer</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Betty ANN EHINGER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 1Box 132 Parsonsborg MD. 21849</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memorial Garden</b>			20c. LOCATION — City or Town, State <b>Hebron MD.</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Seward E. Brund</i>				22. NAME AND ADDRESS OF FACILITY <b>705 E. Main Street Salisbury Maryland 21801</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Cirrhosis obstructive lung disease Congestive heart failure Obesity</b>							Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cirrhosis obstructive lung disease Congestive heart failure Obesity</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael R. Atkins M.D.</i>				29c. LICENSE NUMBER <b>039813</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael R. Atkins, M.D. 1104 Healthway Drive Salisbury, Md</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 22 '91</b>			32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

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Page 12 of 12

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary F. Burks				2. DATE OF DEATH MONTH DAY YEAR 07- 21- 1991		3. TIME OF DEATH 12:45 P M	
4. SOCIAL SECURITY NUMBER 424-20-6937A		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 76 YRS.	7. DATE OF BIRTH (Month, Day, Year) 7/31/14		8. BIRTHPLACE (State or Foreign Country) Alabama	
9a. FACILITY NAME (If not institution, give street and number) Deer's Head Center				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury, Maryland		9c. COUNTY OF DEATH Wicomico	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 11 Deer Harbour Drive				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: African American	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 5+		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College Professor		16b. KIND OF BUSINESS/INDUSTRY University of MD, Eastern Shore			
17. FATHER'S NAME (First, Middle, Last) GUSTAVUS SAMUEL FAIR				18. MOTHER'S NAME (First, Middle, Maiden Surname) OLLIE BEATRICE WILLIAMS			
19a. INFORMANT'S NAME (Type/Print) Dr. Gerald W. Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1221 Coulbourne Mill Rd., Salisbury, MD 21801			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Salisbury Crematory		20c. LOCATION — City or Town, State Salisbury, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lothar B. Sperry</i>				22. NAME AND ADDRESS OF FACILITY JOLLEY MEMORIAL CHAPEL Rt. #2, Box 920, Jersey RD, Salisbury, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cancer of the Head of the Pancreas</u> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>History of Duodenal Ulcer</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Benito S. Chan M.D.</i>		29c. LICENSE NUMBER D20050		29d. DATE SIGNED (Month, Day, Year) 7/21/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Benito S. Chan M.D. Deer's Head Center Salisbury, Md. 21801							
31. DATE FILED (Month, Day, Year) JUL 22 91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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From within the

1855



ESTHER BERGER

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ESTHER MARGARET BERGER</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-01-6609</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-29-12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE, MD</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SALISBURY NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY, MD.</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>834 SHUMAKER PARKWOOD APT. 103</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 Years</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECRETARIAL</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WESTERN ELECTRIC</b>	
17. FATHER'S NAME (First, Middle, Last) <b>FREDRICK (UNK) CASPARE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIAN SCHLAVECKER CASPARE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT HERMAN BERGER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>834 SHUMAKER PARKWOOD APT. 103 SALISBURY, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WICOMICO MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Holloway</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD. SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Suspected Lung Cancer</b> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b> <b>Diphtheria</b> <b>Adenocarcinoma</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Atkins MD</i>				29c. LICENSE NUMBER <b>D39815</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael Atkins MD 1104 Healthway Drive, Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				32. REGISTRAR'S SIGNATURE <i>John M. Holloway</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages

be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21563

1. DECEDENT'S NAME (First, Middle, Last) <b>Sarah Crockett</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:50 p</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>224-10-2577</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>12-16-16</b>		8. BIRTHPLACE (State or Foreign Country) <b>VA</b>		9. FACILITY NAME (If not institution, give street and number) <b>Levindale</b>	
10. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		11. COUNTY OF DEATH <b>Baltimore City</b>		12. RESIDENCE OF DECEDENT	
10a. STATE <b>DC</b>		10b. COUNTY <b>Washington</b>		10c. CITY, TOWN OR LOCATION <b>Washington</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2 - 17th Street SE Apt 7</b>		10f. ZIP CODE <b>20003</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maid</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>		17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lottie Crockett</b>		19a. INFORMANT'S NAME (Type/Print) <b>Nathaniel Crockett</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10.e</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Mem. Park</b>		20c. LOCATION — City or Town, State <b>7/27/91 Landover, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>W.J. Suffer</b>		22. NAME AND ADDRESS OF FACILITY <b>Frazier's Funeral Home</b> <b>389 Rhode Island Avenue, N.W.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Probable Acute Myocardial Infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF): <b>Arterio Sclerotic Cardiovascular Disease</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7/22/91</b>	
28b. TIME OF INJURY <b>11:00</b> <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>Slipped</b>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2434 W Belvedere Ave Baltimore, Md</b>		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Attending MD</b>		29c. LICENSE NUMBER <b>D30951</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A J Luocco 2434 W Belvedere Ave Baltimore, Md</b>		31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>	

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Emily R. CANNON</b>		2. DATE OF DEATH MONTH <b>7</b> - DAY <b>28</b> - YEAR <b>91</b>		3. TIME <b>10:50a</b>	
4. SOCIAL SECURITY NUMBER <b>212-16-1363</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>04/16/1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>WILLIAM HILL HEALTH CARE CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CAMBRIDGE</b>		9c. COUNTY OF DEATH <b>DORCHESTER</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>DORCHESTER</b>		10c. CITY, TOWN OR LOCATION <b>WINGATE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>BOX 2114 FARM CREEK ROAD</b>		10f. ZIP CODE <b>21675</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE/CAUC.</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>CRAB PICKER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SHELLFISH</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>EDWARD G. PRITCHETT</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NARY MILLS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CHRISTINA W. SEAMAN (GRANDDAUGHTER)</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1605 HELIPOINT RD., WOOLFORD, MD. 21677</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DORCHESTER MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>CAMBRIDGE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen H. Brown</i>		22. NAME AND ADDRESS OF FACILITY <b>CURRAN FUNERAL HOME</b> <b>308 HIGH ST., CAMBRIDGE, MD. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ALZHEIMER'S DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death <b>9 YEARS</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GENERALIZED ATHEROSCLEROSIS</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael A. Moskewicz MD.</i>		29c. LICENSE NUMBER <b>D-16609</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/28/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL A. MOSKEWICZ MD. 503 BURN ST. CAMBRIDGE MD</b>			
31. DATE FILED (Month, Day, Year) <b>JUL 29 91</b>		32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN HARRIS COOPER</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>25</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:20A</b>	
4. SOCIAL SECURITY NUMBER <b>214-12-7155-M</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 19, 1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Gorton</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>CHARLES</b>	
10c. CITY, TOWN OR LOCATION <b>PORT TOBACCO</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>ROUTE #6 BOX 1295</b>				10f. ZIP CODE <b>20677</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 8+) <b>NONE</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>GROUND MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES H. COOPER</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE JAMIESON COOPER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CATHERINE BRADFORD</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ROUTE #6 BOX 1295 PORT TOBACCO, MARYLAND 20677</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. CATHERINE S CHURCH CEM. 7/29/91</b>		20c. LOCATION — City or Town, State <b>MC CONCHIE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lydia C. Thornton Johnson</i> <b>LYDIA C. THORNTON JOHNSON</b>		22. NAME AND ADDRESS OF FACILITY <b>THORNTON'S FUNERAL HOME, POMONKEY, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. cardio-Respiratory arrest</b>					
DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
b. <b>status post redo Abdominal Surgery</b>					
DUE TO (OR AS A CONSEQUENCE OF):					
c. <b>arterio-sclerosis general</b>					
DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>AN3255696</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-29-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M.A. NAFICY, MD - 3921-FARMER &amp; SILVER SPRING</b>					
31. DATE FILED (Month, Day, Year) <b>7-29-91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>Mildred Helena Cawunder</b>								2. DATE OF DEATH MONTH DAY YEAR <b>07 24 1991</b>				3. TIME OF DEATH <b>9:15 P M</b>											
4. SOCIAL SECURITY NUMBER <b>219-20-6730</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS <b>6 3</b>		IF UNDER 24 HRS. HOURS MIN. <b>1906</b>		7. DATE OF BIRTH (Month, Day, Year) <b>6 3 1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>Ohio</b>									
9a. FACILITY NAME (If not institution, give street and number) <b>3642 Hoffman Mill Road</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Hampstead</b>				9c. COUNTY OF DEATH <b>Carroll</b>											
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Carroll</b>				10c. CITY, TOWN OR LOCATION <b>Hampstead</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO											
10e. STREET AND NUMBER <b>3642 Hoffman Mill Road</b>								10f. ZIP CODE <b>21074</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>											
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>											
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY															
17. FATHER'S NAME (First, Middle, Last) <b>Martin Courtad</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Von Blon</b>															
19a. INFORMANT'S NAME (Type/Print) <b>Michael Cawunder</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1180 Krentler Drive, Hanover, Pa. 17331</b>															
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Services</b>				20c. LOCATION — City or Town, State <b>Hampstead, Md. 21074</b>															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home</b> <b>934 S. Main Street, Hampstead, Md. 21074</b>																			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>coronary artery disease</b> DUE TO (OR AS A CONSEQUENCE OF): a. b. c. d. <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. c. d. <b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <b>rheumatic heart disease</b> <b>chronic obstructive lung disease</b>												Approximate Interval Between Onset and Death <b>17 years</b>											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO																			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)																			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED													
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)															
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D01079</b>				29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)																							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>								32. REGISTRAR'S SIGNATURE 															

21 51287

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) John Franklin Cooper				2. DATE OF DEATH MONTH DAY YEAR 7 22 91		3. TIME OF DEATH 2:00 P <sup>M</sup>	
4. SOCIAL SECURITY NUMBER 215-26-5912		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 62 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-16-1928	
9a. FACILITY NAME (If not institution, give street and number) U.S. Rte. 13 and Md. Rte. 54				9b. CITY, TOWN OR LOCATION OF DEATH Salisbury		9c. COUNTY OF DEATH Wicomico	
10a. STATE De.				10b. COUNTY Sussex		10c. CITY, TOWN OR LOCATION Laurel	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER Rt. #3 Box 294			
10f. ZIP CODE 19956				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES National Guards		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owned Mens Store		16b. KIND OF BUSINESS/INDUSTRY Cooper's Men Shop			
17. FATHER'S NAME (First, Middle, Last) John Frank Cooper				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mildred Ellis Cooper			
19a. INFORMANT'S NAME (Type/Print) Mark Cooper				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt#3 Box 293A Laurel, De. 19956			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Springhill Memory Gardens		DATE 7-25		20c. LOCATION — City or Town, State Hebron, Md.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Shortt</i>				22. NAME AND ADDRESS OF FACILITY Short Windsor Disharoon Funeral Home, Inc. P.O. Box 678 Laurel, De. 19956			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MULTIPLE INJURIES</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) street					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 7-22-91		28b. TIME OF INJURY 1:40 P <sup>M</sup>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Driver auto truck impact				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Street			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) U.S. Route 13 and Maryland Rte. 54							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) July 23, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Donald G. Wright M.D. 111 Penn St. Baltimore, Md. 21201							
31. DATE FILED (Month, Day, Year) Jul 26 91				32. REGISTRAR'S SIGNATURE <i>John A. Fridman-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

William W. Hall

1892-1893

William W. Hall

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Crowe</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>23</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>12:45 P.M.</b>			
4. SOCIAL SECURITY NUMBER <b>215 58 6743</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>84</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>2-3-1907</b>	8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>FROSTBURG COMMUNITY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FROSTBURG</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>			
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>FROSTBURG</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>21 PARK AVENUE</b>		10f. ZIP CODE <b>21532</b>			
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <input checked="" type="checkbox"/>			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <input checked="" type="checkbox"/>		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>HOUSEWIFE</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>		17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL J. CREEGAN</b>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH STAKEM</b>		19a. INFORMANT'S NAME (Type/Print) <b>JAMES CROWE</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>70 ARMSTRONG ST., FROSTBURG, MD 21532</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. MICHAEL'S CEMETERY</b>		20c. LOCATION — City or Town, State <b>FROSTBURG, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Miniboy M. Sowers</i>		22. NAME AND ADDRESS OF FACILITY <b>SOWERS FUNERAL HOME</b> <b>60 W. MAIN ST., FROSTBURG, MD 21532</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>A.S.C.V.D.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7-23-1991</b>			
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Francisco Reyes MD. Deputy M.E.</b>		29c. LICENSE NUMBER <b>D19316</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-23-1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Francisco Reyes 900 Seton Dr. Cumberland Md. 21502</b>		31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			





91 21570

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) George S. Coleman		2. DATE OF DEATH MONTH 7/ DAY 27/ YEAR 91		3. TIME OF DEATH 5:49 p M	
4. SOCIAL SECURITY NUMBER 217 10 1811		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 1/06/15		8. BIRTHPLACE (State or Foreign Country) W. VA.			
9a. FACILITY NAME (If not institution, give street and number) Frostburg Community Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Frostburg MD		9c. COUNTY OF DEATH Allegany 21532	
10a. STATE MARYLAND		10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION FROSTBURG	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 1 KAYLOR CIRCLE		10f. ZIP CODE 21532	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) UNKNOWN College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY LABORER	
17. FATHER'S NAME (First, Middle, Last) FRANK WASHINGTON COLEMAN		18. MOTHER'S NAME (First, Middle, Maiden Surname) PEARL LINA COMBS			
19a. INFORMANT'S NAME (Type/Print) SILCOX-MERRITT FUNERAL HOME		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 404 DECATUR STREET CUMBERLAND, MARYLAND 21502			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MT. HERMAN CEMETERY JULY 31 1991		20c. LOCATION — City or Town, State CUMBERLAND MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt		22. NAME AND ADDRESS OF FACILITY SILCOX-MERRITT FUNERAL HOME 804 DECATUR STREET CUMBERLAND MARYLAND			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Cardiac arrest Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST possible acute myocardial infarction Cellulitis both lower leg peripheral vascular disease PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Chronic obstructive lung disease Congestive heart failure					Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. S. Kim		29c. LICENSE NUMBER D15463		29d. DATE SIGNED (Month, Day, Year) 7/29/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. S. Kim, Main St., Westernport MD 21562					
31. DATE FILED (Month, Day, Year) JUL 30 1991		32. REGISTRAR'S SIGNATURE John Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>KATHRYN G. BLUM</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>30</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1:23 A.M.</b>			
4. SOCIAL SECURITY NUMBER <b>213 30 6372</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct. 6, 1932</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>3 Riverview Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Severna Park</b>				9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Severna Park</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>3 Riverview Road</b>				10f. ZIP CODE <b>21146</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>David R. Gillespie</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Falice Marks</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Robert W. Blum</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Riverview Road, Severna Park, MD 21146</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cem.</b>		20c. LOCATION — City or Town, State <b>Arlington, VA</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald L. Lyle Jr.</i>		22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Adenocarcinoma Lung</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>1 month</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Emilio W. Cole MD</b>						29c. LICENSE NUMBER <b>D16354</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/30/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E.W. COLE 51 FRANKLIN ST ANNAPOLIS MD 21401</b>											
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21572

1. DECEDENT'S NAME (First, Middle, Last) <i>CAROLYN S. CLARK</i>		2. DATE OF DEATH MONTH <i>7</i> DAY <i>27</i> YEAR <i>91</i>		3. TIME OF DEATH <i>4:30 PM</i>	
4. SOCIAL SECURITY NUMBER <i>066-28-6164</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>89</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>9-14-1901</i>		8. BIRTHPLACE (State or Foreign Country) <i>Vermont</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Water View Healthcare Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Salisbury</i>		9c. COUNTY OF DEATH <i>Wicomico</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Wicomico</i>		10c. CITY, TOWN OR LOCATION <i>Delmar</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>Rt #3-93 Lot 4B</i>		10f. ZIP CODE <i>21875</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <i>Elementary/Secondary (0-12)</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Own Home</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Horace Warner Strong</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Ella Anna Brown</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Elaine Milne</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>Same as 10.</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parsons Cemetery</i>		20c. LOCATION — City or Town, State <i>Salisbury, Maryland</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Guilford C. Bounds</i>		22. NAME AND ADDRESS OF FACILITY <i>Bounds Funeral Home, Salisbury, Md.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multiple pulmonary emboli</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Atherosclerotic Heart Disease</i> DUE TO (OR AS A CONSEQUENCE OF): <i>Chronic atrial fibrillation</i> DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>S/P Multiple CVAs</i> <i>Abdominal aortic aneurysm</i> <i>Chr. atrial fibrillation</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. J. Huddleson</i>		29c. LICENSE NUMBER <i>D29105</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/29/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>C. J. Huddleson MD. Poplar St. Fruitland.</i>					
31. DATE FILED (Month, Day, Year) <i>JUL 29 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

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91 21573

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Paul G. Cayaves</b>				2. DATE OF DEATH MONTH <b>JULY</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2:05</b> M	
4. SOCIAL SECURITY NUMBER <b>220-44-3291</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-18-1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New York</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>310 Wyman Drive</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army/AF WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Physician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medicine</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George P. Cayaves</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Keryacula Marco</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Elsie M. Cayaves</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10e</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Eastern Crematorium</b>		20c. LOCATION — City or Town, State <b>7/30 Georgetown, DE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gerald C. Brunel</b>				22. NAME AND ADDRESS OF FACILITY <b>Bounds F.H. 705 E. Main St Salisbury</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Subdural Hematoma</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Arterio Prosthatic Valve, Diabetes, Hypertension</b>							Approximate Interval Between Onset and Death <b>7-3 day</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arterio Prosthatic Valve, Diabetes, Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D26612</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-28-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Crouch; 105 Pine Bluff Rd, Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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MADLYN CALLOWAY

91 21574

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MADLYN BENNETT CALLOWAY</b>				2. DATE OF DEATH MONTH <b>7-</b> DAY <b>20-</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:30 P M</b>				
4. SOCIAL SECURITY NUMBER <b>217-10-3583</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-19-03</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>SALISBURY NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY, MD.</b>			9c. COUNTY OF DEATH <b>WICOMICO</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>DELMAR</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>RT. 3 MALLARD DRIVE</b>				10f. ZIP CODE <b>21875</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10 Years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSE WIFE</b>			15b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM H. BENNETT</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY M. WILKINS</b>						
19a. INFORMANT'S NAME (Type/Print) <b>ROSALIE C. DOLBEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>RT. 3 MALLARD DR. DELMAR, MD 21875</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARSONS CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John H. Holloway</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD. SALISBURY, MD 21801</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Respiratory Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes</i> <i>Severe osteoporosis</i>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Atkins MD</i>				29c. LICENSE NUMBER <b>259815</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael Atkins MD 1104 Healthway Drive, Salisbury, Md. 21801</b>										
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

CONFIDENTIAL

SI 51234

*Handwritten signature*

187512

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21575

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) THOMAS CLYDE COLLINSON JR.				2. DATE OF DEATH MONTH DAY YEAR 07 20 1991		3. TIME OF DEATH 7:04 P M	
4. SOCIAL SECURITY NUMBER 219-32-8190		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT. 08, 1933	
8a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL				8b. CITY, TOWN OR LOCATION OF DEATH BALITMORE CITY		8c. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH BALITMORE CITY		9c. COUNTY OF DEATH BALTIMORE CITY	
10a. STATE MARYLAND		10b. COUNTY WORCESTER		10c. CITY, TOWN OR LOCATION BISHOPVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 12426 NORTH PINEY POINT ROAD				10f. ZIP CODE 21813		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Contractor		16b. KIND OF BUSINESS/INDUSTRY Construction			
17. FATHER'S NAME (First, Middle, Last) THOMAS C. COLLINSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) FRANCES E. BAGBY			
19a. INFORMANT'S NAME (Type/Print) JOANN B. COLLINSON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12426 NORTH PINEY POINT ROAD, BISHOPVILLE, MD 21813			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ZION CHURCH CEMETERY 7-24-91		20c. LOCATION — City or Town, State BISHOPVILLE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Hastings</i>				22. NAME AND ADDRESS OF FACILITY HASTINGS FUNERAL HOME SELBYVILLE, DELAWARE 19975			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Ischemic heart disease</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Chronic renal failure</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 10 yrs 5 yrs							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Diabetes</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER MARCO A. MEJIA, MD Intern				29c. LICENSE NUMBER J8114		29d. DATE SIGNED (Month, Day, Year) 7/20/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MARCO A. MEJIA, MD Johns Hopkins Hosp.							
31. DATE FILED (Month, Day, Year) 7/20/91 JUL 23 91				32. REGISTRAR'S SIGNATURE <i>John F. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21576

1. DECEASED'S NAME (First, Middle, Last) <b>Chester Leon Collins</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 20 1991</b>		3. TIME OF DEATH M <b>0930</b>	
4. SOCIAL SECURITY NUMBER <b>219-14-3541</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-1-1923</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>BENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10. RESIDENCE OF DECEASED			
10a. STATE <b>MD.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Pocomoke MD</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1210 Market st</b>				10f. ZIP CODE <b>21851</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Blk.</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maritancee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N.A.S.A.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charlie Collins</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gussie Gaston Wilson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linda Collins</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 181 GEETREE, MD 21829</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Little Georgetown Cemetery 7/27/91</b>		20c. LOCATION — City or Town, State <b>Pocomoke, MD</b>		20d. DATE <b>7/27/91</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Russell Forks</b>				22. NAME AND ADDRESS OF FACILITY <b>Funeral Home P.O. Box 1574 Salisbury MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Staphylococcal Septicemia</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Angio-stroke Rel. Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Renal Osteodystrophy</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>- Staphylococcal Septicemia</b> <b>- Angio-stroke Rel. Disease</b> <b>- Renal Osteodystrophy</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Benito S. Chan MD</b>				29c. LICENSE NUMBER <b>D-20050</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BENITO S. CHAN 547-D Kinsley Dr. Solby, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

01 51216

FOX 617

10/15/01

10/15/01

91 21577

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William E. Davis</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>09</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:45 pm</b>	
4. SOCIAL SECURITY NUMBER <b>579-07-0694</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-5-12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Dist. of Columbia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fairland Nsg. Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>College Park,</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>5116 Kenesaw St.</b>	
10f. ZIP CODE <b>20740</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>None</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Courier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Walter E. Davis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Virginia Wiggington</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James E. Saylor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5116 Kenesaw St., College Park, Md. 20740</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parklawn Cemetery</b>		20c. LOCATION — City or Town, State <b>Rockville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul G. Buhner</i>				22. NAME AND ADDRESS OF FACILITY <b>Gasch's Funeral Home., 4739 Baltimore Ave., Hyattsville, Md. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Pneumonia</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William E. Davis</i>				29c. LICENSE NUMBER <b>024942</b>		29d. DATE SIGNED (Month, Day, Year) <b>19 July 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GREENY A COMPTON MD 8317 Cherry Lane Laurel MD</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Hendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

6

91 51211



1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Tyrone Downton</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>17</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:52 AM</b>	
4. SOCIAL SECURITY NUMBER <b>Unavailable</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>14</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 22, 1977</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Takoma Pk, Md.</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Prince Georges Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>		9c. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>P.G.</b>		10c. CITY, TOWN OR LOCATION <b>Landover</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7226 Landover Rd., #B</b>				10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>8th Grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Student</b>		15b. KIND OF BUSINESS/INDUSTRY <b>None</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Wade Lee Downton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah McKeive</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sarah Downton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7226 Landover Rd., #B, Landover, Md. 20785</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		DATE <b>7-23-91</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>James E. Vann F.H.</b> <b>4804 Georgia Ave., N.W., Wash., D.C. 20011</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Gunshot Wound to Abdomen</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>7-17-91</b>		28b. TIME OF INJURY <b>3:00A M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28e. DESCRIBE HOW INJURY OCCURRED <b>Subject Shot</b>			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>7226 Landover Rd. Landover, P.G. Co.</b>					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Randall</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 17, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Frank J. Peretti M.D. 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 51278

91-3822-033

ITEMS: 9a, b, c, 28f per ME  
G-680 10/22/91 cm

91 21579

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) AN-RICO DAVIS				2. DATE OF DEATH MONTH DAY YEAR 07 09 91		3. TIME OF DEATH 12:06 A M	
4. SOCIAL SECURITY NUMBER 578-90-8951		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 17 YRS.		7. DATE OF BIRTH (Month, Day, Year) Mar. 22, 1974	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGE'S GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH WASHINGTON, D.C.	
9c. COUNTY OF DEATH PRINCE GEORGE'S				10a. STATE DC N/A			
10b. COUNTY N/A				10c. CITY, TOWN OR LOCATION Washington, D.C.			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 3778 Hayes St., NE #2			
10f. ZIP CODE 20019				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10th College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Student/Unemployed		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) John Davis				18. MOTHER'S NAME (First, Middle, Maiden Surname) Estelle Taylor			
19a. INFORMANT'S NAME (Type/Print) Sylvia Taylor				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3778 Hayes St, NE #2 Wash, DC 20019			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington National Cem. 7/13/91		20c. LOCATION — City or Town, State Suitland, MD		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert G. Mason</i>	
22. NAME AND ADDRESS OF FACILITY Robert G. Mason Funeral Home 1661 Good Hope Rd, SE Wash, DC 20020				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 07/08/91		28b. TIME OF INJURY 11:30P		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED Subject shot		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) STREET		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 5800 BLAINE STREET NE WASHINGTON DC			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Donald G. Wright MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 07/09/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT M.D. DCME 111 PENN STREET, BALTIMORE, MARYLAND 21202							
31. DATE FILED (Month, Day, Year) JUL 24 '91		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

81 51219

ITEM:4 per FH  
G-678 8/29/91 cm

91 21580

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Delfin Gonzaga DelRosario, Jr.</u>				2. DATE OF DEATH MONTH <u>07</u> DAY <u>19</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>7:15P</u>				
4. SOCIAL SECURITY NUMBER <u>215-56-6431</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>60</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11-08-30</u>		8. BIRTHPLACE (State or Foreign Country) <u>Philippines</u>		
9a. FACILITY NAME (If not institution, give street and number) <u>Doctors Community Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Lanham</u>			9c. COUNTY OF DEATH <u>Princes George's</u>			
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince George's</u>		10c. CITY, TOWN OR LOCATION <u>Bowie</u>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <u>12303 Keel Turn</u>				10f. ZIP CODE <u>20715</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>Filipino</u>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12</u> College (1-4 or 5+) <u>4</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Civil Eng./Estimator</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Construction</u>						
17. FATHER'S NAME (First, Middle, Last) <u>Delfin del Rosario, Sr.</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Teofista Gcnzaga</u>						
19a. INFORMANT'S NAME (Type/Print) <u>Esperanza V. del Rosario</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>12303 Keel Turn, Bowie, Maryland 20715</u>						
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Lee Crematory</u>		DATE <u>07-22-91</u>		20c. LOCATION — City or Town, State <u>Clinton, Maryland</u>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <u>Lee Funeral Home, Inc.</u> <u>6633 Old Alexander Ferry Rd., Clinton, Md.</u>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Sepsis</u> a. DUE TO (OR AS A CONSEQUENCE OF): <u>Turnine Nox-Hodgkin Lymphoma</u> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <u>24 hrs</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>- NONE -</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <u>John Davidson-Randall</u>				29c. LICENSE NUMBER <u>026197</u>		29d. DATE SIGNED (Month, Day, Year) <u>7-19-91</u>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>9300 Lexington Avenue, MD; Lanham, MD 20706</u>										
31. DATE FILED (Month, Day, Year) <u>JUL 26 91</u>				32. REGISTRAR'S SIGNATURE <u>John Davidson-Randall</u>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

12. 12. 1947  
I am not sure if it is a bird or not.

12. 12. 1947  
I am not sure if it is a bird or not.

91 21581

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT E. DURNER</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:20</b> a M	
4. SOCIAL SECURITY NUMBER <b>705-07-4098</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06 04 13</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7528 OLD COALING ROAD</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>HARMANS</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>	
10c. CITY, TOWN OR LOCATION <b>HARMANS</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7528 OLD COALING ROAD</b>	
10f. ZIP CODE <b>21077</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>0</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ASSISTANT SIGNAL MAINTAINER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>RAILROAD TRANSPORTATION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ELSIE DURNER</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ETHEL GARDNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CATHERINE A. DURNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7528 OLD COALING ROAD-HARMANS, MD. 21077</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FRIENDSHIP CEMETERY</b>		DATE <b>7/30</b>		20c. LOCATION — City or Town, State <b>HARMANS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Darryl L. Kaufman</i>				22. NAME AND ADDRESS OF FACILITY <b>RAYMOND C. FINK FUNERAL HOME 21061 426 CRAIN HWY. S.W. GLEN BURNIE, MD.</b>			
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable Arrhythmia</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Ischemic Heart Disease</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>Immediate</b> <b>3 weeks</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>N/A</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		25a. DATE OF INJURY (Month, Day, Year)		25b. TIME OF INJURY <b>M</b>		25c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		25e. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Marc Okun MD</i>				29c. LICENSE NUMBER <b>DZ8000</b>		29d. DATE SIGNED (Month, Day, Year) <b>07/28/91.</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARC OKUN M.D. 203 HOSPITAL DRIVE-SUITE 206, GLEN BURNIE, MD. 21061</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 1991</b> <i>John [Signature]</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 51281



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLADYS ETHEL DARNEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 5, 1991</b>		3. TIME OF DEATH <b>9:20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>577-09-4238</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>MARCH 14, 1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>MASS.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BAYSIDE NURSING CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LEXINGTON PARK</b>		9c. COUNTY OF DEATH <b>ST. MARY'S CO.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S COUNTY</b>		10c. CITY, TOWN OR LOCATION <b>MECHANICSVILLE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. 1, BOX 500</b>				10f. ZIP CODE <b>20659</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +) <b>1 YEAR</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EDWARD JAMES DARVIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA HAWKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EDARD JAMES DARNEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2590 SANDGATES RD., MECHANICSVILLE, MD. 20659</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. ZION UNITED METHODIST 8/08/91</b>		DATE <b>LAUREL GROVE, MD.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Abigail H. Simmons</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <i>Cardio pulmonary Failure</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Coronary Artery De</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <i>not yes</i>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> QUALIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J. Patrick Jarboe</i>				29c. LICENSE NUMBER <b>D06419</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-6-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. PATRICK JARBOE, M.D. LEONARDTOWN, MARYLAND 20650</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 07 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					



91-4208-510

ITEMS:10c,19b per FH ITEM:27 per ME  
 G-678 8/29/91 cm G-679 9/20/91 cm  
 ITEM:10e per FH  
 G-678 8/14/91 cm

91 21583

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
 CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KIM R. DERR</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>163-62-5848</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>24 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>6-18-1967</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				9a. FACILITY NAME (If not institution, give street and number) <b>304 W. BALTIMORE STREET (REAR)</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Pennsylvania</b>		10b. COUNTY <b>Lehigh</b>	
10c. CITY, TOWN OR LOCATION <b>Lower Macungie Township</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1472 LAUREL LANE</b> <b>1472 Laura Lane</b>	
10f. ZIP CODE <b>18062</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unemployed</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>		17. FATHER'S NAME (First, Middle, Last) <b>Donald W. Derr</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Joan Schaffer</b>		19a. INFORMANT'S NAME (Type/Print) <b>Donald W. Derr</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1472 Laura Lane Lower Macungie, Pennsylvania 18062</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ziegels Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Breinigsville, Pennsylvania</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael P. Marzullo</b>		22. NAME AND ADDRESS OF FACILITY <b>Marzullo Funeral Service</b> <b>3981 Carrollton Road Upperco, Maryland 21155</b>		23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Multiple Injuries</b>		Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Rear of building</b>	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>07/23/91</b>		28b. TIME OF INJURY <b>3:25 PM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject jumped from roof</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>building</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>304 W. BALTIMORE STREET (REAR)</b>		29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael P. Marzullo</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>07/24/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SMIALEK 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>	
31. DATE FILED (Month, Day, Year) <b>JUL 30 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51283

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR Nephie Thomas Davis  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21584

1. DECEDENT'S NAME (First, Middle, Last) <b>Nephie Thomas Davis</b>		2. DATE OF DEATH DAY <b>28</b> MONTH <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:25 PM</b>	
4. SOCIAL SECURITY NUMBER <b>231-18-4397</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 26, 1900</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>		9. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Waldorf</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2645 Hamilton Place</b>		10f. ZIP CODE <b>20602</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>-</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY <b>VMI College</b>		17. FATHER'S NAME (First, Middle, Last) <b>Thomas Reid Staton</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Betty Richard Taylor</b>		19a. INFORMANT'S NAME (Type/Print) <b>Barbara A. Donaldson</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2645 Hamilton Pl, Apt. 203, Waldorf, Md. 20602</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greene Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Buena Vista, Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE EMPLOYEE <b>Michael Blankenship</b>		22. NAME AND ADDRESS OF FACILITY <b>Huntt Funeral Home</b> <b>P. O. Box 156, Waldorf, Md. 20604-0156</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death) → Congestive Heart Failure, refractory.</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Underlying Cause: Hypertensive Cardiovascular Disease</b> <b>Sepsis</b> <b>Urinary tract infection</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7/29/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>		29c. LICENSE NUMBER <b>D-20824</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>9450 Penn. Ave. #18 Upper Mer/Boro, MD 20772</b>		31. DATE FILED (Month, Day, Year) <b>JUL 31 '91</b>	
32. REGISTRAR'S SIGNATURE <b>Nephie Thomas Davis</b>		33. DATE OF DEATH <b>7/28/91</b>		34. TIME OF DEATH <b>10:25 PM</b>	

91 51284

91 21585

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Luther J. Etchison, SR.</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 A</b> M	
4. SOCIAL SECURITY NUMBER <b>577-16-4140</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>89</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-15-02</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>				9. FACILITY NAME (If not institution, give street and number) <b>3002 Arundel Road apt 3</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>MT Ranier</b>	
11. COUNTY OF DEATH <b>Prince George</b>				12. STATE <b>MD</b>		13. COUNTY <b>Prince George</b>	
14. CITY, TOWN OR LOCATION <b>MT Ranier</b>				15. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		16. STREET AND NUMBER <b>3002 Arundel Road apt 3</b>	
17. ZIP CODE <b>20712</b>				18. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		19. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
23. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) _____				24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		25. KIND OF BUSINESS/INDUSTRY <b>U.S. Govt.</b>	
26. FATHER'S NAME (First, Middle, Last) <b>Ernest Etchison</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada King</b>			
28. INFORMANT'S NAME (Type/Print) <b>Luther J. Etchison, Jr.</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>617 Dunberry Drive, Arnold, Maryland 21012</b>			
30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lincoln Cemetery 07/24/91</b>		32. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
33. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				34. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
<b>Arteriosclerotic Cardiovascular Disease</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one)			
HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA				OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> Deputy Medical Examiner				29c. LICENSE NUMBER <b>501852</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-21-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DeKOE MD 4203 Queensbury Rd Hyattsville MD 20781</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 51282



91 21586

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARVIN LEE ELLIOTT, SR.</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 A M</b>	
4. SOCIAL SECURITY NUMBER <b>234 48 8382</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>56 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>9-7-34</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. FACILITY NAME (If not institution, give street and number) <b>6941 FOREST TERRACE</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>LANDOVER</b>				11. COUNTY OF DEATH <b>Prince George</b>			
12a. STATE <b>MD</b>		12b. COUNTY <b>Prince George</b>		12c. CITY, TOWN OR LOCATION <b>LANDOVER</b>		12d. INSIDE CITY LIMITS? <b>1 X YES 2 NO</b>	
13. STREET AND NUMBER <b>6941 FOREST TERRACE</b>				14. ZIP CODE <b>20785</b>		15. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
16. MARITAL STATUS <b>1 X Never Married 2 Married 3 Widowed 4 Divorced</b>		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b>		19. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>		21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Barber</b>		22. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
23. FATHER'S NAME (First, Middle, Last) <b>Robert Elliott, Sr.</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kathelene Freeman</b>			
25. INFORMANT'S NAME (Type/Print) <b>Eva B. Elliott</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6941 Forest Terrace Landover, MD 20785</b>			
27a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 7-30 Landover, Maryland</b>		27c. LOCATION — City or Town, State			
28. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jimmy G. Neal</i>				29. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Myocardial Infarction</b>						Approximate Interval Between Onset and Death <b>hours</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. Arteriosclerotic Cardiovascular Disease</b>						<b>years</b>	
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						24b. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>	
						24c. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 X YES 2 NO</b>		26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>		27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28. DATE OF INJURY (Month, Day, Year) <b>N/A</b>	
29. TIME OF INJURY <b>M</b>		29c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED			
29e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				29f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 X MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Deputy Medical Examiner</i>		29c. LICENSE NUMBER <b>Δ01852</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-26-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE, MD 42036 Queensbury Rd Myerstown Pa 20781</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 '91</b>		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ENCLOSURE

13.1/13.1

91 21587

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gloria Everhart</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:10 A M</b>	
4. SOCIAL SECURITY NUMBER <b>219-74-4433</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-30-50</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Frances Scott Key</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1041 Quantril Way</b>	
10f. ZIP CODE <b>21205</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>8</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Food Server</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Irvin Ellis Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rose Mefford</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rose Ellis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>515 Bruce Avenue, Odenton, MD 21113</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakeview Cemetery</b>		20c. LOCATION — City or Town, State <b>Sykesville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Pat J. Ambler</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Septic</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. pancreatic cancer</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>1 wk</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James W. Weber, D.O.</b>				29c. LICENSE NUMBER <b>JO 9537</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CJ WINCHELL MD</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 31 1991</b>				32. REGISTRAR'S SIGNATURE <b>John A. Anderson</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Rayner A. FUNK</u>				2. DATE OF DEATH MONTH <u>07</u> DAY <u>19</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>5:00P</u> M	
4. SOCIAL SECURITY NUMBER <u>579-05-0323</u>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>86</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>June 15, 1905</u>	
8. BIRTHPLACE (State or Foreign Country) <u>Pennsylvania</u>				9a. FACILITY NAME (If not institution, give street and number) <u>Doctor's Community Hospital</u>		9b. CITY, TOWN OR LOCATION OF DEATH <u>Lanham</u>	
9c. COUNTY OF DEATH <u>Prince George's</u>				10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince George's</u>	
10c. CITY, TOWN OR LOCATION <u>Lanham</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <u>6135 Princess Garden Parkway</u>	
10f. ZIP CODE <u>20706</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>1927-1933</u>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <u>12</u> College (1-4 or 5+) <u>College</u>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Ordinance Man</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Naval Ordnance Laboratory</u>			
17. FATHER'S NAME (First, Middle, Last) <u>William Funk</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>UNKNOWN</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Anna Funk</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>6135 Princess Garden Pkwy, Lanham, Maryland 20706</u>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Fort Lincoln Cemetery 7-22-91</u>			
20c. LOCATION — City or Town, State <u>Brentwood, Maryland</u>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Richard Dender</u>			
22. NAME AND ADDRESS OF FACILITY <u>Rendon-Hale Lanham Funeral Home</u> <u>9013 Annapolis Road, Lanham, Maryland 20706</u>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>a. Cardiac Arrest</u> Due to (OR AS A CONSEQUENCE OF): b. <u>Respiratory Insufficiency</u> Due to (OR AS A CONSEQUENCE OF): c. <u>Coronary Heart Failure</u> Due to (OR AS A CONSEQUENCE OF): d. <u>Congestive Heart Failure</u> Due to (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M <u>1</u> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>Steven S. Remsen MD</u>			
29c. LICENSE NUMBER <u>019446</u>				29d. DATE SIGNED (Month, Day, Year) <u>7/20/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Steven S. Remsen 8118 Good Luck Rd Lanham MD 20706</u>				31. DATE FILED (Month, Day, Year) <u>JUL 23 '91</u>			
32. REGISTRAR'S SIGNATURE <u>Juan Davidson-Randall</u>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MICHAEL E FUNDERBURKE				2. DATE OF DEATH 07 PM 91		3. TIME OF DEATH 4:28 A	
4. SOCIAL SECURITY NUMBER 577 82 3060		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 30 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5/23/91	
9a. FACILITY NAME (If not institution, give street and number) MALCOLM GROW HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CAMP SPRINGS		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE MARYLAND				10b. COUNTY PRINCE GEORGES		10c. CITY, TOWN OR LOCATION FORESTVILLE	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER 7309 MASON STREET			
10f. ZIP CODE 20747				10g. CITIZEN OF WHAT COUNTRY? UNITED STATES			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 09 College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) LABORER		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION	
17. FATHER'S NAME (First, Middle, Last) DAVID SYDNOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) ZULEE FUNDERBURKE			
19a. INFORMANT'S NAME (Type/Print) ZULEE FUNDERBURKE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7309 MASON ST FORESTVILLE MD 20747			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) HARMONY MEMORIAL PARK 7/20		20c. LOCATION — City or Town, State LANDOVER MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i>				22. NAME AND ADDRESS OF FACILITY ALEXANDER S POPE FUNERAL HOME 2617 PA AVE SE WASH DC 20020			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARDIAC ARRHYTHMIA DUE TO (OR AS A CONSEQUENCE OF): b. GENERALIZED SARCOIDOSIS AND COCAINE INTOXICATION DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 7/14/91		28b. TIME OF INJURY UNKNOWN		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED UNKNOWN		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) UNKNOWN		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) UNKNOWN			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 07/15/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) FRANK J PEROTTI 111 PENN STREET BALTIMORE, MARYLAND 21202							
31. DATE FILED (Month, Day, Year) JUL 22 '91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY LOU FINKLE				2. DATE OF DEATH MONTH DAY YEAR JULY 28 1991		3. TIME OF DEATH M 3:00p	
4. SOCIAL SECURITY NUMBER 577-46-1092		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 57 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/09/1933	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL			
10. RESIDENCE OF DECEDENT 10a. STATE: Maryland 10b. COUNTY: Charles 10c. CITY, TOWN OR LOCATION: La Plata				11. CITY, TOWN OR LOCATION OF DEATH: LA PLATA			
12. COUNTY OF DEATH: CHARLES				13. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
14. STREET AND NUMBER 4058 Farewell Court				15. ZIP CODE 20646		16. CITIZEN OF WHAT COUNTRY? U.S.A.	
17. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		18. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		19. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		20. RACE — American Indian, Black, White, etc. Specify: White	
21. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 2 College (1-4 or 5+)		22. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Real Estate Agent		23. KIND OF BUSINESS/INDUSTRY Long & Foster Co. Real Estate			
24. FATHER'S NAME (First, Middle, Last) Alton Boone				25. MOTHER'S NAME (First, Middle, Maiden Surname) Lilia Price			
26. INFORMANT'S NAME (Type/Print) Clarence T. Finkle				27. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4058 Farewell Court, La Plata, Md. 20646			
28. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		29. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Epiphany Episcopal Cemetery Forestville, Md.		30. LOCATION — City or Town, State			
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>SC Echols Jr.</i>		32. NAME AND ADDRESS OF FACILITY AREHART FUNERAL HOME, INC. P.O. Box 567, La Plata, Md. 20646					
33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Coronary Artery Disease</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
34. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		35. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
36. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		37. DATE OF INJURY (Month, Day, Year)		38. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		39. DESCRIBE HOW INJURY OCCURRED	
39. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		40. SIGNATURE AND TITLE OF CERTIFIER <i>George H. Wathen</i>		41. LICENSE NUMBER D-20629		42. DATE SIGNED (Month, Day, Year) 7/29/91	
43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE H. WATHEN M.D. PEMBROKE SQUARE #104 HIGHWAY 301 S. WALDORF MD 20603							
44. DATE FILED (Month, Day, Year) JUL 31 '91		45. REGISTRAR'S SIGNATURE <i>Lilia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51231

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B.O.

ITEMS:23,27 per ME

G-679 9/6/91 cm

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Mary Jane Elliott</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 01 1991</b>		3. TIME OF DEATH <b>4:45 PM</b>	
4. SOCIAL SECURITY NUMBER <b>217-42-5054</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>48</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-16-43</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>413 Prince Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>	
10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>413 PRINCE STREET</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (1-4 or 5+) <b>6 YEARS</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>PUBLIC SCHOOL SYSTEM</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JAMES T. ELLIOTT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY EMILY ADKINS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES T. ELLIOTT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1827 MT. HERMON RD SALISBURY, MD 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SPRINGHILL MEMORY GARDENS</b>		DATE <b>8-4</b>		20c. LOCATION — City or Town, State <b>HEBRON, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD. SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. MYOCARDIAL RIGHT VENTRICULAR DYSPLASIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 02 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann M. Dixon, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 09 '91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21593

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) OTTO EMORY FORD				2. DATE OF DEATH MONTH DAY YEAR JULY 24 1991		3. TIME OF DEATH 6 00 P M	
4. SOCIAL SECURITY NUMBER 215-18-4554		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 101 YRS.		7. DATE OF BIRTH (Month, Day, Year) 05-18-1890	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO				10a. STATE Maryland		10b. COUNTY Somerset	
10c. CITY, TOWN OR LOCATION Princess Anne				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 218 Pineknoll Drive	
10f. ZIP CODE 21853				10g. CITIZEN OF WHAT COUNTRY? U.S.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+) 6				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		16b. KIND OF BUSINESS/INDUSTRY Seafood	
17. FATHER'S NAME (First, Middle, Last) George Ford				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia Dize			
19a. INFORMANT'S NAME (Type/Print) Mrs. Elsie W. Ford				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 218 Pineknoll Drive, Pr. Anne, md. 21853			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Beechwood Cemetery 7/27 Pr. Anne, md. 21853		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James J. Hinman M00295				22. NAME AND ADDRESS OF FACILITY Hinman Funeral Home Princess Anne, md. 21853			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>aspiration pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>parkinsonism</u> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval between Onset and Death < 24h							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Charles B. Silva Jr MD PGHMC				29c. LICENSE NUMBER D30853		29d. DATE SIGNED (Month, Day, Year) 7/24/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles B. Silva Jr MD PGHMC				31. DATE FILED (Month, Day, Year) JUL 26 '91			
32. REGISTRAR'S SIGNATURE Julia Davidson-Randall				33. DATE OF DEATH (Month, Day, Year) JUL 24 '91			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHV





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Siavias J Ghenatneri				07 18 91				0615 M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
458 29 0770		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		40 YRS.		8/1/50		SHIRAZ IRAN			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
SHADY GROVE HOSPITAL				ROCKVILLE				MONTGOMERY			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
MD		MONTGOMERY		BETHESDA		X <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
7828 CUSTER ROAD				20814				UNITED STATES			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: IRANIAN					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) N.A.				College (1-4 or 5+) MAINTENANCE				RESEARCH CENTER			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
MOHAMAD GHBNATNEVI				GAHAN FOLTAN							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
ZAHRA GHBNATNEVI				7828 CUSTER RD BETHESDA MD 20814							
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				NATIONAL MEMORIAL PARK				FALLS CHURCH VA			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
<i>Alex S. Pope Jr.</i>				ALEXANDER S POPE FUNERAL HOME MD-859							
				2617 PA AVE SE WASH DC 20020							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								15			
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
a. <i>myocardial infarction</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>congestive heart failure</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
c. <i>old myocardial infarction</i>											
DUE TO (OR AS A CONSEQUENCE OF):											
d. <i>congestive heart failure</i>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
<i>old myocardial infarction + congestive heart failure</i>								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURED	
1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER							
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				<i>James Frisbon</i>							
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
				24971				7/18/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
James Frisbon 15225 SHADY GROVE RD, Rockville											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
JUL 22 '91				<i>Julia Davidson-Randall</i>							

at 1250

91 21595

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNE Loretta GILL</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>09:55 PM</b>	
4. SOCIAL SECURITY NUMBER <b>216-60-9448</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01-12-11</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Baltimore, MD</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Arnold</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>305 College Parkway</b>				10f. ZIP CODE <b>21012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Hairdresser</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hairdressing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Joseph Scanlon</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Mary Murphy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jane Pumphrey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1918 Marconi Circle, Annapolis, MD 21401</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Memorial Park</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>TARDIVE DYSKINESIA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>Attending MD</b>				29c. LICENSE NUMBER <b>21776</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SURYA P. MUNDRA, M.D./1600 CRAIN HIGHWAY, SW #308/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 31 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20212 12

20212 12

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21596

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT ORLANDO GALE</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-09-1035</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>11-13-11</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Rt. #1, Box 372</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Eden</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Eden</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Route #1, Box 372</b>		10f. ZIP CODE <b>21822</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>African American</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Shoreland Freezer</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Louis Gale</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bethena Gale &amp; Beatrice Evans</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. #1, Box 372, Eden, Maryland 21822</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Friendship Church Cemetery</b>		20c. LOCATION — City or Town, State <b>Allen, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Potencia Alley Lashley</i>		22. NAME AND ADDRESS OF FACILITY <b>Rt. #2, Box 920, Jersey RD Jolley Memorial Chapel, Salisbury, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. metastatic Small Cell Lung Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph A. Grasso</i>		29c. LICENSE NUMBER <b>D20507</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph A. Grasso 145 E. CARROLL ST Salisbury MD</b>			
31. DATE FILED (Month, Day, Year) <b>JUL 26 91</b>		32. REGISTRAR'S SIGNATURE <i>John A. Smith</i>			

91 51222



91 21597

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LINDA KAY GARTNER</b>				2. DATE OF DEATH MONTH <b>July</b> DAY <b>28</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>12:30P</b> M	
4. SOCIAL SECURITY NUMBER <b>213-44-1595</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (in yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APRIL 6 1945</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>				9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ALLEGANY</b>		10c. CITY, TOWN OR LOCATION <b>CUMBERLAND</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>409 DECATUR STREET</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>HOUSEKEEPER</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HAUSRATH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CATHERINE FAIR</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DENNIS D. GARTNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>409 DECATUR STREET CUMBERLAND, MARYLAND</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FROSTBURG MEMORIAL PARK JULY 31 1991 FROSTBURG MARYLAND</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dale L. Merritt</i>				22. NAME AND ADDRESS OF FACILITY <b>SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Massive acute subarachnoid hemorrhage</i></b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>K. Heder Ashker MD</i>				29c. LICENSE NUMBER <b>D-26471</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Ashker Memorial Hospital Medical Center, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51297

1.  $\mathbb{R}^n$  is a vector space over  $\mathbb{R}$ .



91 21598

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>HENRY ALPHONSO GRAY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 29, 1991</b>		3. TIME OF DEATH <b>11:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-12-1481</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 24, 1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ST. MARY'S HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>LEONARDTOWN</b>	
9c. COUNTY OF DEATH <b>ST. MARY'S</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>	
10c. CITY, TOWN OR LOCATION <b>AVENUE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>BOX 5</b>	
10f. ZIP CODE <b>20609</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1941 - 1945</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8TH. GRADE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FARMER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>FARM</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ANDREW JESSIE GRAY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALICE CATHERINE GRAY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE LEE BEITZELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>BOX 5, AVENUE, MARYLAND 20609</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHARLES MEMORIAL GARDENS 7/31/91</b>		20c. LOCATION — City or Town, State <b>LEONARDTOWN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebrovascular Accident</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>William D. Boyd, II</i>		29c. LICENSE NUMBER <b>D14285</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/30/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM D. BOYD, II LEONARDTOWN, MARYLAND 20650</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 02 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Harry B. Gwathney</i>				2. DATE OF DEATH MONTH <i>7</i> DAY <i>21</i> YEAR <i>91</i>		3. TIME OF DEATH <i>6:22 P M</i>	
4. SOCIAL SECURITY NUMBER <i>721 18 4065</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>84</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>9/23/'06</i>	
8. BIRTHPLACE (State or Foreign Country) <i>New York</i>				9. COUNTY OF DEATH <i>Prince Georges</i>			
10. RESIDENCE OF DECEDENT 10a. STATE <i>Maryland</i> 10b. COUNTY <i>Prince George's</i> 10c. CITY, TOWN OR LOCATION <i>Brandywine</i> 10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>14320 Brandywine Road</i>				10f. ZIP CODE <i>20613</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>43-45</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Service Technician</i>		16b. KIND OF BUSINESS/INDUSTRY <i>TV Maintenance and Repair</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Charles Gwathney</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Margaret Tate</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mae Gwathney</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>14320 Brandywine Rd., Brandywine, MD. 20613</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Lee's Funeral Home 7/23/91 Clinton, MD.</i>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lloyd H. Hester</i>				22. NAME AND ADDRESS OF FACILITY <i>Adams Funeral Home, P.A.</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac Dysrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Respiratory Insufficiency</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>COPD</i> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Aortic Aneurysm</i>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward L. Haye MD</i>				29c. LICENSE NUMBER <i>026352</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/22/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Edward L. Haye MD 931 Piscataway Rd Clinton Md 20735</i>							
31. DATE FILED (Month, Day, Year) <i>JUL 31 '91</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>Donald K. Gray</i>				2. DATE OF DEATH MONTH DAY YEAR 7 27 91				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 220-16-8416		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 65 YRS.		7. DATE OF BIRTH (Month, Day, Year) 5 8 1926		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 918 FRANKLIN MANOR ROAD				9b. CITY, TOWN OR LOCATION OF DEATH CHURCHTON				9c. COUNTY OF DEATH ANNE ARUNDEL	
10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION CHURCHTON				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 918 FRANKLIN MANOR RD.				10f. ZIP CODE 20733		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W.W.II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ENGINEER				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) CHARLES GRAY				18. MOTHER'S NAME (First, Middle, Maiden Surname) IVA FOUNTAIN					
19a. INFORMANT'S NAME (Type/Print) MARY GRAY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 918 FRANKLIN MANOR RD. CHURCHTON, MD. 20733					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MARYLAND VETERAN CEME.		20c. LOCATION — City or Town, State CROWNSVILLE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY 821 WEST ST ANNAPOLIS, MD. 21401 REESE & SONS MORTUARY, P.A.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Metastatic Cancer, Primary Lung</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death <i>2 years</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>R. L. Hochman, MD</i>	
29c. LICENSE NUMBER D5192				29d. DATE SIGNED (Month, Day, Year) 7/30/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard I. Hochman 16 Murray Ave Annapolis md 21401									
31. DATE FILED (Month, Day, Year) JUL 30 1991				32. REGISTRAR'S SIGNATURE <i>Julia Anderson-Henderson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY Hubbard</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>17</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5:03A M</b>	
4. SOCIAL SECURITY NUMBER <b>259 42 4782</b>		5. SEX <b>M</b>		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/11/30</b>		8. BIRTHPLACE (State or Foreign Country) <b>LaGRANGE GA</b>	
9. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital</b>				10. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>				11. COUNTY OF DEATH <b>Prince Georges</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>		10c. CITY, TOWN OR LOCATION <b>CLINTON</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4535 NATAHALA DRIVE</b>				10f. ZIP CODE <b>20735</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>7/30/54 6/23/56</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>POLICEMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>US GOVERNMENT</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM B HUBBARD</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE LOVELACE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>TERESA JONES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4535 NATAHALA DR CLINTON MD 20735</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MACKEY &amp; WILSON F.H.</b>		DATE <b>7/21</b>		20c. LOCATION — City or Town, State <b>LAGRANGE GA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Alex S. Pope Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>ALEXANDER S POPE FUNERAL HOME 2617 PA AVE SE WASH DC 20020</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Sepsis</b> b. <b>Due to (or as a consequence of):</b> c. <b>Due to (or as a consequence of):</b> d. <b>Due to (or as a consequence of):</b>								Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>myocardial infarction - suspect</b> <b>hypertensive cardiovascular disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Helen Capone MD</b>				29c. LICENSE NUMBER <b>DO 1180</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/17/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Helen Capone MD</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 22 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 51601



91 21602

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LULA E HAMMERBACHER</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>31</b> YEAR <b>91</b>		3. TIME OF DEATH <b>01:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>217-34-5764</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 11 1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>FAIRPORT VA.</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		9c. COUNTY OF DEATH <b>A.A. COUNTY</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>A.A.CO.</b>		10c. CITY, TOWN OR LOCATION <b>PASADENA</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>264 N. FERRY POINT ROAD</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 grade</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>housewife</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HAMILTON P. HARRIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LULA ELIZABETH BLUNDEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HOWARD W. HAMMERBACHER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>264 N. FERRY POINT RD. PASADENA, MD 21122</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN CEMTERY 8/2/91</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ed J. Stally</i>				22. NAME AND ADDRESS OF FACILITY <b>STALLINGS FUNERAL HOME 3111 MOUNTAIN RD. PASADENA MD. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b></b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED <b></b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Authean, M.D.</i>				29c. LICENSE NUMBER <b>D36192</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/31/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANEES AHSAN, M.D./1600 CRAIN HIGHWAY, SW #201/GLEN BURNIE, MARYLAND 21061</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 01 1991</b>				32. REGISTRAR'S SIGNATURE <i>Jane Burdon-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 1100

at 1100

91 21603

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY ELLEN HAXTER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7-21-91</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>218-16-8223</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-17-25</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>ZION CHURCH ROAD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>WICOMICO</b>		10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>ZION CHURCH ROAD</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PLANT WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>POULTRY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ISAAC (UNK) DISE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BRAZOLA CROCKETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BERNARD HAXTER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 34 PARSONSBURG, MD 21849</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SPRINGHILL MEMORY GARDENS</b>		20c. LOCATION — City or Town, State <b>HEBRON, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Holloway</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL ROAD SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause for each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Allen M.D.</i>					
		29c. LICENSE NUMBER <b>D29168</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/23/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert Allen M.D. 560 Riverside Dr. Salisbury MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE <i>John M. Holloway</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21604	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) WALTER EDWARD Hoffman				2. DATE OF DEATH MONTH DAY YEAR July 25, 1991		3. TIME OF DEATH 0745 M			
4. SOCIAL SECURITY NUMBER 217-16-9655		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 68 YRS.	7. DATE OF BIRTH (Month, Day, Year) 4-12-23		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO			
10a. STATE MD				10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION SALISBURY		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 407 WOODCREST				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Army		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 YEARS		College (1-4 or 5+) 2 Years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) METER FORMAN		16b. KIND OF BUSINESS/INDUSTRY POWER UTILITY			
17. FATHER'S NAME (First, Middle, Last) WALTER (UNK) HOFFMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) THELMA (UNK) HOFFMAN					
19a. INFORMANT'S NAME (Type/Print) DORIS JEAN HOFFMAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 WOODCREST AVE. SALISBURY, MD 21801					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		7-29-91		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARSONS CEMETERY		DATE 7-29		20c. LOCATION — City or Town, State SALISBURY, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Holloway</i>				22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME 501 SNOW HILL RD SALISBURY, MD 21801					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hepatic Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Acute Myocardial Infarction Alcohol-Induced Cardiac Arrest						Approximate Interval Between Onset and Death 1 Day			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Pneumonia, Respiratory Failure				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>John S. Green</i>		29c. LICENSE NUMBER D02020		29d. DATE SIGNED (Month, Day, Year) 7/25/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John Green, Green Salisbury MD 21801									
31. DATE FILED (Month, Day, Year) JUL 26 '91		32. REGISTRAR'S SIGNATURE <i>John S. Green</i>							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) HILDA REGINA HEWLETT				2. DATE OF DEATH MONTH 8 DAY 3 YEAR 91		3. TIME OF DEATH 0920 A. M.	
4. SOCIAL SECURITY NUMBER 579-22-6375		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	7. DATE OF BIRTH (Month, Day, Year) October 17, 1909		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) BAYSIDE NURSING CENTER				9b. CITY, TOWN OR LOCATION OF DEATH LEXINGTON PARK		9c. COUNTY OF DEATH ST. MARY'S	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY ST. MARY'S		10c. CITY, TOWN OR LOCATION DAMERON		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER P.O. BOX 99				10f. ZIP CODE 20628		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) -----				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CUSTODIAN		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) JOSEPH ADAM BISCOE				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROXY LANGLEY BISCOE			
19a. INFORMANT'S NAME (Type/Print) RICHARD JAMES HEWLETT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. BOX 99, DAMERON, MARYLAND 20628			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. PETER CLAVERS CEMETERY 8/7		20c. LOCATION — City or Town, State ST. INIGOE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Brinkley</i>				22. NAME AND ADDRESS OF FACILITY BRINSFIELD FUNERAL HOME, P.A. LEONARDTOWN, MARYLAND 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Card Arrhythmia</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Coronary Ulcer</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Antical carcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. J. J. /</i>				29c. LICENSE NUMBER D33470		29d. DATE SIGNED (Month, Day, Year) 8/6/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BHASKER JHAVERI, MD Shanti Medical Center, Leonardtown, Maryland 20650							
31. DATE FILED (Month, Day, Year) AUG 07 '91				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21606

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHRYN Kathryn Belle Hildebran</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>01.30 PM</b>			
4. SOCIAL SECURITY NUMBER <b>212-32-3171</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-25-03</b>		8. BIRTHPLACE (State or Foreign Country) <b>OHIO</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>WESTMINSTER NUR &amp; CONVCTR WESTMINSTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>WESTMINSTER</b>			9c. COUNTY OF DEATH <b>CARROLL</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Westminster</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>203 Pennsylvania Ave.</b>				10f. ZIP CODE <b>21157</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>5+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>professor</b>			16b. KIND OF BUSINESS/INDUSTRY <b>college</b>				
17. FATHER'S NAME (First, Middle, Last) <b>William G. Hildebran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kittie Baker</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Carroll L. Yingling</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>70 Ridge Rd. Westminster, MD 21157</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input checked="" type="checkbox"/> Other (Specify) <b>entombment</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Knollwood Memorial Mausoleum</b>			20c. LOCATION — City or Town, State <b>Mayfield Hgts., Ohio</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Catharine D. Hartzler</i>				22. NAME AND ADDRESS OF FACILITY <b>D.D. Hartzler &amp; Sons New Windsor, MD</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. TERMINAL PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. CEREBRAL VASCULAR ACCIDENT</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. ARTERIO SCLEROTIC CARDIO-CEREBRAL VAS DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>d.</b>								Approximate interval Between Onset and Death <b>2 DAYS</b> <b>7 DAYS</b> <b>10 YEARS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel I. Welliver</i>				29c. LICENSE NUMBER <b>D11496</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-26-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DANIEL I. WELLIVER MD 912 WASHINGTON ROAD WESTMINSTER MD 21157</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 30 '91</b>		32. REGISTRAR'S SIGNATURE <i>Gelia Davidson-Randall</i>							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LENA S. Houghton</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4AM</b>
4. SOCIAL SECURITY NUMBER <b>168-40-1092</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>78</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>11-30-12</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>403 Fawn Haven Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Millersville</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Millersville</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER <b>403 Fawn Haven Court</b>		10f. ZIP CODE <b>21108</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12+</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Registered Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital Industry</b>
17. FATHER'S NAME (First, Middle, Last) <b>William Stoupe</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Selina Latimar</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Verna Glass</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>403 Fawn HAVEN Court Millersville, MD 21108</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barranco</i>		22. NAME AND ADDRESS OF FACILITY <b>Barranco &amp; Sons Severna Park, Funeral Home 495 Ritchie Highway Severna Park, MD 21146</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CVA - brainstem hemorrhage</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. <b>ARCVD</b> - DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		
		29c. LICENSE NUMBER <b>D-18809</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 27, 1991</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>600 Ridge Ave Suite 133 Annapolis Md 21401</b>				
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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Handwritten signature or text at the bottom of the page.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21608

1. DECEDENT'S NAME (First, Middle, Last) <i>Helee V. Huffer</i>		2. DATE OF DEATH MONTH <i>07</i> DAY <i>26</i> YEAR <i>91</i>		3. TIME OF DEATH <i>12:45 P M</i>	
4. SOCIAL SECURITY NUMBER <i>213-01-1021</i>		5. SEX <i>1</i> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>78</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>06/18/13</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>		9. COUNTY OF DEATH <i>Anne Arundel</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Anne Arundel Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Annapolis M</i>		9c. COUNTY OF DEATH <i>Anne Arundel</i>	
RESIDENCE OF DECEDENT					
10a. STATE <i>Md.</i>		10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Annapolis</i>	
10d. INSIDE CITY LIMITS? <i>1</i> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>6 Oak Court</i>		10f. ZIP CODE <i>21401</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>7</i> College (1-4 or 5+) <i>College</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Courier</i>		16b. KIND OF BUSINESS/INDUSTRY <i>State of Maryland</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Clarence F. Huffer</i>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Alice Virginia Kefauver</i>		
19a. INFORMANT'S NAME (Type/Print) <i>Ruth R. Huffer</i>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6 Oak Court, Annapolis, Maryland 21401</i>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Hillcrest Cemetery 7/29</i>		20c. LOCATION — City or Town, State <i>Annapolis, MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles E. Arnyer</i>		22. NAME AND ADDRESS OF FACILITY <i>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Severe congestive heart failure</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Coronary artery disease</i> <i>Diabetic Mellitus c renal Failure</i>					Approximate Interval Between Onset and Death <i>Month</i> <i>Yrs</i> <i>Yrs.</i> <i>Wks</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Generalized atherosclerosis</i> <i>Hypertension</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph N. Friend M.D.</i>		29c. LICENSE NUMBER <i>017965</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/26/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Joseph N. Friend 205 Rutledge Ave. Annapolis, MD</i>					
31. DATE FILED (Month, Day, Year) <i>JUL 30 1991</i>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			



Reva Hastings

91 21609

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) REVA LEE HASTINGS				2. DATE OF DEATH MONTH 7 DAY 25 YEAR 91		3. TIME OF DEATH 9:55 P M				
4. SOCIAL SECURITY NUMBER 214-12-6540		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 89 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-28-01		8. BIRTHPLACE (State or Foreign Country) MARYLAND		
9a. FACILITY NAME (If not institution, give street and number) SALISBURY NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY, MD.			9c. COUNTY OF DEATH WICOMICO			
10a. STATE MD		10b. COUNTY WICOMICO		10c. CITY, TOWN OR LOCATION SALISBURY			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER Rt. 1 Levin Dashiell Rd.				10f. ZIP CODE 21830		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7 YEARS		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SEAMRESS		15b. KIND OF BUSINESS/INDUSTRY CLOTHING MFG.						
17. FATHER'S NAME (First, Middle, Last) WILLIAM ERWIN PARSONS				16. MOTHER'S NAME (First, Middle, Maiden Surname) LULU MAE LOWE						
19a. INFORMANT'S NAME (Type/Print) CAROLYN H. MOORE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) RT. 1 BOX 32A HEBRON, MD 21830						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) SPRINGHILL MEMORIAL PARK 7-29		DATE 7-29		20c. LOCATION — City or Town, State HEBRON, MARYLAND				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John M. Holloway</i>				22. NAME AND ADDRESS OF FACILITY HOLLOWAY FUNERAL HOME 501 SNOW HILL RD SALISBURY, MD 21801						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cerebral Anoxia</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute Hematuria, High Blood Pressure, Atherosclerosis, Osteoporosis</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER P40K50		29d. DATE SIGNED (Month, Day, Year) 7/26/91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) EDDIE VELAZQUEZ, M.D. 1104 HEALTHWAY DRIVE, SALISBURY, MD. 21801										
31. DATE FILED (Month, Day, Year) JUL 29 '91				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 1000

1000

1000



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <i>Caroline W. James</i>				2. DATE OF DEATH MONTH DAY YEAR <i>7-25-1991</i>	
3. TIME OF DEATH <i>2:30 A</i>		4. SOCIAL SECURITY NUMBER <i>214-26-0930</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	
6. AGE (In yrs. last birthday) <i>60</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>May 31, 1931</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Hartford Memorial Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Havre de Grace</i>	
9c. COUNTY OF DEATH <i>Hartford</i>				10a. STATE <i>Maryland</i>	
10b. COUNTY <i>Cecil</i>		10c. CITY, TOWN OR LOCATION <i>Perryville</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>695 Jackson Station Road</i>				10f. ZIP CODE <i>21903</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>College (1-4 or 5+)</i> <i>One Year</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Dietetics Dept.</i>				16b. KIND OF BUSINESS/INDUSTRY <i>Citizens Nursing Home</i> <i>Havre de Grace, Maryland</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Collins S. Williams, Sr.</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Frances Dykes</i>	
19a. INFORMANT'S NAME (Type/Print) <i>Bernard L. James, Sr.</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>695 Jackson Station Road, Perryville, Md. 21903</i>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Berkley Cemetery</i> <i>7/29/91</i>	
20c. LOCATION — City or Town, State <i>Darlington, Maryland</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas M. Patterson, Sr.</i>	
22. NAME AND ADDRESS OF FACILITY <i>Lee A. Patterson &amp; Son Funeral Home</i> <i>Perryville, Maryland 21903</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac failure, arrhythmia</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <i>severe coronary arteries disease 3 yrs</i>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):	
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>pending gangrene R leg &amp; foot</i> <i>from severe PVD</i> <i>chronic renal failure, on Heparin</i>				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. J. M.</i>				29c. LICENSE NUMBER <i>A5502</i>	
29d. DATE SIGNED (Month, Day, Year) <i>7-25-91</i>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>M. J. M., MD. 433 Girard St., Hdb, MD 21078</i>	
31. DATE FILED (Month, Day, Year) <i>7-28-91</i>				32. REGISTRAR'S SIGNATURE <i>John F. ...</i>	

NOV 19 1964

NOV 19 1964

91 21611

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLARENCE JACKSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 14 91</b>		3. TIME OF DEATH <b>9:00A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-30-8978</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>156</b>		7. DATE OF BIRTH (Month, Day, Year) <b>OCT 30 '34</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>801 Quade Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Oxon Hill</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Oxon Hill Street</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>801 Quade Street</b>			
10f. ZIP CODE <b>20745</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>Jan. 1955</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0-6th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dept. of Public Works</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Jackson, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jaunita Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Curley Jean Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>801 Quade St., Oxon Hill, Md. 20745</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill</b>		20c. LOCATION — City or Town, State <b>Suitland, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Curley Jean Jackson</i>		22. NAME AND ADDRESS OF FACILITY <b>Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E. Wash., DC 20020</b>					
23. PART I. Enter the diseases, or complications, that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiac arrest sudden</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>coronary artery disease</b> <b>hypertensive arteriosclerotic cardiovascular disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Alzheimer's mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall MD</i>				29c. LICENSE NUMBER <b>D12879</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 14, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Davidson-Randall MD, 10701 TRUSTON DR, LARGO, MD 20772</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


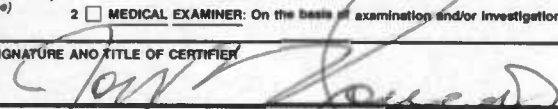
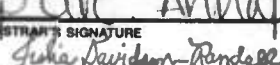
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21612

1. DECEDENT'S NAME (First, Middle, Last) <b>Jean Frances Jones</b>				2. DATE OF DEATH MONTH DAY YEAR <b>07/22/91</b>		3. TIME OF DEATH <b>7:20 PM M</b>	
4. SOCIAL SECURITY NUMBER <b>579-38-7850</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/15/23</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Pleasant Living N. H.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Edgewater</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Adelphi</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8422 20th Ave.,</b>				10f. ZIP CODE <b>20783</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Computer Opr.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Arbitron</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Eugene Lewis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie Thomason</b>			
19a. INFORMANT'S NAME (Type, Print) <b>Dorothy B. Lewis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>104 Pine Crest Drive, Annapolis, Md. 21403</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Port Lincoln Cemetery</b>		20c. LOCATION — City or Town, State <b>Brentwood, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>1218529</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-23-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>600 Rindley Ave Annapolis MD 21401 Jon Lowe MD</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE 			

21 51915

x

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21613

1. DECEDENT'S NAME (First, Middle, Last) WILMER Bernard JOHNSON		2. DATE OF DEATH MONTH DAY YEAR JULY 28 1991		3. TIME OF DEATH 2:55p M	
4. SOCIAL SECURITY NUMBER 214-16-7292		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 06/06/1905		8. BIRTHPLACE (State or Foreign Country) Maryland		9. FACILITY NAME (If not institution, give street and number) PHYSICIANS MEMORIAL HOSPITAL	
10. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION OF DEATH LA PLATA	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER One Magnolia Drive		10f. ZIP CODE 20646	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6 College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waterman		16b. KIND OF BUSINESS/INDUSTRY Seafood Industry Self Employed		17. FATHER'S NAME (First, Middle, Last) Philip J. Johnson	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Lena E. Lacey		19a. INFORMANT'S NAME (Type/Print) Evelyn Heenan		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1224 Port Echo Lane, Bowie, Md. 20716	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Holy Ghost Cemetery		20c. LOCATION — City or Town, State Issue, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE S C Echols		22. NAME AND ADDRESS OF FACILITY AREHART FUNERAL HOME, INC. P.O. Box 567, La Plata, Md. 20646		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Prostate Cancer a. DUE TO (OR AS A CONSEQUENCE OF): Partial Bowel Obstruction b. DUE TO (OR AS A CONSEQUENCE OF): Alcoholic Disease c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER George H. Wathen M.D.		29c. LICENSE NUMBER D-20629	
29d. DATE SIGNED (Month, Day, Year) 7/29/91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GEORGE H. WATHEN M.D. PEMBROKE SQUARE #104 HIGHWAY 301 S., WALDORF MD 20603		31. DATE FILED (Month, Day, Year) JUL 29 '91	
32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21614			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) MARTIN ROBERT JONES				2. DATE OF DEATH MONTH DAY YEAR July 26, 1991				3. TIME OF DEATH 13:14 P.M.			
4. SOCIAL SECURITY NUMBER 216-28-3886		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/06/1929		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) Physicans Memorial Hospital				9b. CITY, TOWN OR LOCATION OF DEATH La Plata				9c. COUNTY OF DEATH Charles			
10a. STATE Maryland		10b. COUNTY Charles		10c. CITY, TOWN OR LOCATION White Plains				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER P.O. Box 218				10f. ZIP CODE 20695				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 +				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Retired County Extension Agent				16b. KIND OF BUSINESS/INDUSTRY State of Maryland			
17. FATHER'S NAME (First, Middle, Last) Edwin Phillip Jones				18. MOTHER'S NAME (First, Middle, Maiden Surname) Evelyn Augusta Kolbe							
19a. INFORMANT'S NAME (Type/Print) Virginia Lee Jones				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 218, White Plains, Md. 20695							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baldwin Memorial Meth. Cem. Millersville, Md.				20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE S. C. Echols				22. NAME AND ADDRESS OF FACILITY AREHART FUNERAL HOME, INC. P.O. Box 567, La Plata, Md. 20646							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <u>infarction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>metastatic adenocarcinoma of unknown primary site, brain metastases</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>primary site, brain metastases</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u></u> DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER D. J. HAYDAK MD								29c. LICENSE NUMBER D17605		29d. DATE SIGNED (Month, Day, Year) 7/29/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) D. J. HAYDAK MD											
31. DATE FILED (Month, Day, Year) JUL 29 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21615					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) WILLIAM F. Johnson				2. DATE OF DEATH MONTH DAY YEAR July 20, 1991				3. TIME OF DEATH 2200 M					
4. SOCIAL SECURITY NUMBER 218-05-8065		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 93 YRS.		7. DATE OF BIRTH (Month, Day, Year) 3-19-1898		8. BIRTHPLACE (State or Foreign Country) Va.					
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO					
10a. STATE Md.				10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Mardela Springs				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER P.O. Box 27 Main St.				10f. ZIP CODE 21837				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) assemblyman				16b. KIND OF BUSINESS/INDUSTRY Dresser Wayne					
17. FATHER'S NAME (First, Middle, Last) William H. Johnson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Johnson Allen (Maiden unknown)									
19a. INFORMANT'S NAME (Type/Print) Janie Brown Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) P.O. Box 27 Main St. Mardela Springs, Md. 21837									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mardela Cemetery		20c. DATE 7-23		20d. LOCATION — City or Town, State Mardela, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE William M. Shortz				22. NAME AND ADDRESS OF FACILITY Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cerebrovascular accident DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death 48 hours					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER Charles B. Silva Jr MD		29c. LICENSE NUMBER D30853		29d. DATE SIGNED (Month, Day, Year) 7/20/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Charles B. Silva Jr MD PGHMC													
31. DATE FILED (Month, Day, Year) JUL 22 91													

at 1212

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SECRET

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21616

1. DECEDENT'S NAME (First, Middle, Last) <b>Leigh C. KENYON</b>				2. DATE OF DEATH MONTH <b>July</b> DAY <b>19</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>2:25 P M</b>					
4. SOCIAL SECURITY NUMBER <b>579-38-8204</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 8, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>Dist. of Columbia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Doctors Community Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>				9c. COUNTY OF DEATH <b>Prince George</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George's</b>				10c. CITY, TOWN OR LOCATION <b>University Park</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4208 Underwood St.</b>						10f. ZIP CODE <b>20772</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>none</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Monotype Operator</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U. S. Gov't Printing Off.</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Elbert S. Kenyon</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Coshun</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Sharon K. Paternaster</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4910 W. Chalk Point Rd., W. River, Md. 20778</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 7/22/91</b>				20c. LOCATION — City or Town, State <b>Brentwood, Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Mark A. Brohman</i>						22. NAME AND ADDRESS OF FACILITY <b>Gasch's Funeral Home, 4739 Baltimore Ave., Hyattsville, Md. 20781</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Anemia, Thrombocytopenia, leukopenia, lymphoma</b> <b>Approximate Interval Between Onset and Death</b> <b>days</b> <b>days</b> <b>days</b> <b>months</b>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.													
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James J. Kim, M.D.</i>						29c. LICENSE NUMBER <b>D16191</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-20-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James J. Kim, M.D., 10694 Campusway S., Largo, MD 20772</b>													
31. DATE FILED (Month, Day, Year) <b>JUL 23 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

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at state

91 21617

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KERR, Robert S.</b>		2. DATE OF DEATH MONTH <b>07</b> DAY <b>31</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0545 AM</b>
4. SOCIAL SECURITY NUMBER <b>159-12-6077</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>73</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>03/23/18</b>	8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS, MD</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>
10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2569 Golfers Ridge Road</b>		
10f. ZIP CODE <b>21401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>President/Supplier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Norwood Inc. Construction Materials</b>		
17. FATHER'S NAME (First, Middle, Last) <b>J. Calvin Kerr</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah McCracken</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Rachel A. Kerr</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2569 Golfers Ridge Road, Annapolis, MD</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Deer Creek Cemetery</b>		20c. LOCATION — City or Town, State <b>Harmar Township, PA</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Barth J. ...</i>		22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 21401 12 Ridgely Avenue, Annapolis, MD</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>pancreatic CA</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY  28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stuart E. Selouch, M.D.</b>  29c. LICENSE NUMBER <b>019838</b>  29d. DATE SIGNED (Month, Day, Year) <b>7/31/91</b>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stuart E. Selouch, M.D. 57 Franklin St Annapolis, Md. 21401</b>  31. DATE FILED (Month, Day, Year) <b>AUG 01 1991</b>  32. REGISTRAR'S SIGNATURE <i>John Davidson</i>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2 & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21618					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Donald Edward Knight, Sr.				2. DATE OF DEATH MONTH DAY YEAR 7-26-91				3. TIME OF DEATH 12 <sup>30</sup> P M					
4. SOCIAL SECURITY NUMBER 216-28-9107		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 59 YRS.		7. DATE OF BIRTH (Month, Day, Year) Sept. 2, 1931		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Fallston General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Fallston				9c. COUNTY OF DEATH Harford					
10a. STATE Maryland				10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Bel Air		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 608 W. Ring Factory Road				10f. ZIP CODE 21014				10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Truck Driver				16b. KIND OF BUSINESS/INDUSTRY Chemical					
17. FATHER'S NAME (First, Middle, Last) Paul Rufus Knight				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Mae Hickman									
19a. INFORMANT'S NAME (Type/Print) A. Joyce Knight				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 608 W. Ring Factory Road, Bel Air, Md.									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Bel Air Memorial Gardens 7-30-91		DATE 7-30-91		20c. LOCATION — City or Town, State Bel Air, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Howard K. McComas III				22. NAME AND ADDRESS OF FACILITY Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009									
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SMALL CELL LUNG CANCER DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST LIVER METASTASES DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. LIVER METASTASES								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER John P. Edwards, M.D.		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 7/26/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) John P. Edwards, M.D. Fallston, Maryland 21047													
31. DATE FILED (Month, Day, Year) JUL 29 '91				32. REGISTRAR'S SIGNATURE John Davidson-Randall									

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Edmond T KOSCIANSKI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 25, 1991</b>		3. TIME OF DEATH <b>4:43 P M</b>	
4. SOCIAL SECURITY NUMBER <b>162-26-0766</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-16-33</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rosedale</b>		9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4418 Cole Farm RD</b>				10f. ZIP CODE <b>21236</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>High School</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Baker - Supervisor</b>		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Koscianski</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Siemianowski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Donna J. Koscianski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4418 Cole Farm Rd., Baltimore, MD 21236</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>All Saints Cemetery 07-29-91</b>		20c. LOCATION — City or Town, State <b>Reisterstown, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kenneth B. Eline</i>				22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home Reisterstown, MD 21136</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Pulmonary embolism</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>history of recent myocardial infarction and coronary artery bypass</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>McCrath</i>				29c. LICENSE NUMBER <b>D20907</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>On Chatham 9000 Franklin Square Drive, Baltimore, MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PAUL WILLIAM KEATLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1991</b>		3. TIME OF DEATH <b>8:10 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-9220</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>DEC. 12, 1924</b>	
8. BIRTHPLACE (State or Foreign Country) <b>DELAWARE</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtown</b>	
9c. COUNTY OF DEATH <b>St. Mary's</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S CO.</b>	
10c. CITY, TOWN OR LOCATION <b>VALLEYLEE</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>P.O. BOX 60, McKAYS BEACH</b>	
10f. ZIP CODE <b>20692</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1943-1946</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) <b>4 YEARS</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COMPUTER ANALYST</b>				16b. KIND OF BUSINESS/INDUSTRY <b>I.R.S.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MILLARD F. KEATLEY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN MARIE JENKINS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ROBENA M. KEATLEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. BOX 60, VALLEY LEE, MARYLAND 20692</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>ST. GEORGE CATHOLIC CEMETERY 8/5/91 VALLEY LEE, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Diabetes</b> <b>Chronic Obstructive Pulmonary Disease</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Chronic Obstructive Pulmonary Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>8-2-91</b>			
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Patrick Jarboe M.D.</i>				29c. LICENSE NUMBER <b>DO6419</b>			
29d. DATE SIGNED (Month, Day, Year) <b>8-2-91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PATRICK JARBOE M.D. LEONARDTOWN</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 07 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21621

1. DECEDENT'S NAME (First, Middle, Last) William Robert Kern				2. DATE OF DEATH MONTH 07/26/91 YEAR		3. TIME OF DEATH M				
4. SOCIAL SECURITY NUMBER 216-12-7696		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH MONTH 12/22/22		8. BIRTHPLACE (State or Foreign) Michigan		
9a. FACILITY NAME (If not institution, give street and number) 13 Kimberly Court				9b. CITY, TOWN OR LOCATION OF DEATH Severna Park			9c. COUNTY OF DEATH Anne Arundel			
10a. STATE MD		10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Severna Park			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 13 Kimberly Court				10f. ZIP CODE 21146		10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES 07/11/54		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Caucasian				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Ass. Mgr./Sales Repres.		16b. KIND OF BUSINESS/INDUSTRY Steamship Business						
17. FATHER'S NAME (First, Middle, Last) George Robert Kern				18. MOTHER'S NAME (First, Middle, Maiden Surname) Alice Evans Kern						
19a. INFORMANT'S NAME (Type/Print) Mrs. Ruth S. Kern				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 Kimberly Court Severna Park MD 21146						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Lakemont Mem. Garden		20c. LOCATION — City or Town, State Davidsonville, MD						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Baranco</i>		22. NAME AND ADDRESS OF FACILITY 495 Ritchie Hwy. Barranco Funeral Home Severna Park MD 21146								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinoma of Prostate</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James E. Baranco</i>				29c. LICENSE NUMBER 1001315		29d. DATE SIGNED (Month, Day, Year) 7-29-91				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 600 Ridgely Ave Suite 135										
31. DATE FILED (Month, Day, Year) JUL 30 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Fordell</i>						


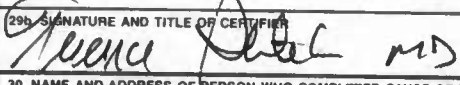
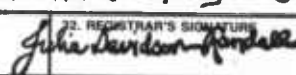
21 51851



91 21622

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Susie Kellam</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>24</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:31a</b> M	
4. SOCIAL SECURITY NUMBER <b>578-22-8743</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-28-1895</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>Prince George</b>	
9b. FACILITY NAME (If not institution, give street and number) <b>Southern Maryland Hospital</b>							
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince Georges</b>		10c. CITY, TOWN OR LOCATION <b>Bladensburg</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5999 Emerson Street</b>				10f. ZIP CODE <b>20710</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>9</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard Turlington</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Elizabeth Ashby</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Beth Kellam</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3203 Flowers Rd. Upper Marlboro, MD 20772</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Belle Haven Cemetery</b>		DATE <b>7-27</b>		20c. LOCATION — City or Town, State <b>Belle Haven, Va.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>495 Ritchie Highway Barranco Funeral Home Severna Park MD 21146</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ADENOCARCINOMA OF COLON.</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER <b>D30054</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>7501 JUDITHS RD CLINTON MD 20735</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature and date: 10/10/55

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH	
Edward J. Lynch, Sr.				7-20-91	
4. SOCIAL SECURITY NUMBER				3. TIME OF DEATH	
188-28-2143				4:10 PM	
5. SEX				8. BIRTHPLACE (State or Foreign Country)	
1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F				Pennsylvania	
6. AGE (In yrs. last birthday)				7. DATE OF BIRTH	
59 YRS.				6/11/32	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH	
FRANCIS SCOTT KEY MEDICAL CENTER				BALTIMORE	
9c. COUNTY OF DEATH				10d. INSIDE CITY LIMITS?	
Baltimore City				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE				10c. CITY, TOWN OR LOCATION	
Maryland				Elkton	
10b. COUNTY				10f. ZIP CODE	
Cecil				21921	
10e. STREET AND NUMBER				10g. CITIZEN OF WHAT COUNTRY?	
135 Midland Drive				U.S.A.	
11. MARITAL STATUS				12. WAS DECEDENT EVER IN U.S. ARMED FORCES?	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				IF YES, GIVE WAR OR DATES	
				Sept. 1949 - Dec. 1952	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.	
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)	
Elementary/Secondary (0-12)				Engineer	
12				16b. KIND OF BUSINESS/INDUSTRY	
College (1-4 or 5+)				Electronic Corporation	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)	
John Joseph Lynch				Elizabeth Marie O'Shea	
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)	
Margaret M. Lynch				135 Midland Drive Elkton, MD 21921	
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)	
1 <input checked="" type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				Valley Forge Mem. Gardens 7-25 1991	
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20c. LOCATION — City or Town, State	
				King of Prussia, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY	
Donald J. Hicks				Hicks Home for Funerals, P.A. Bow and Stockton Streets Elkton, MD 21921	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.				Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				0	
a. ASHY STOLE					
DUE TO (OR AS A CONSEQUENCE OF):					
b. SEPSIS				5 Days	
DUE TO (OR AS A CONSEQUENCE OF):					
c. SMALL BOWEL OBSTRUCTION				3 weeks	
DUE TO (OR AS A CONSEQUENCE OF):					
d. SMALL BOWEL TUMOR				?	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED?	
				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)	
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation				28b. TIME OF INJURY	
2 <input type="checkbox"/> Accident				M	
3 <input type="checkbox"/> Suicide				28c. INJURY AT WORK?	
4 <input type="checkbox"/> Homicide				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
8 <input type="checkbox"/> Could not be determined				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)				29b. LICENSE NUMBER	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29d. DATE SIGNED (Month, Day, Year)	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				7/20/91	
29c. SIGNATURE AND TITLE OF CERTIFIER				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print)	
Patricia A. Davidson				Patricia A. Davidson MD 2120	
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE	
JUL 24 1991				Patricia Davidson-Randall	

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NEWMAN P. LINDSAY</b>		2. DATE OF DEATH MONTH <b>JULY</b> DAY <b>14</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:55P</b> M	
4. SOCIAL SECURITY NUMBER <b>577 16 4962</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH MONTH <b>AUG</b> DAY <b>19</b> YEAR <b>'14</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>MALCOLM GROW HOSPITAL</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>CLINTON</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>PRINCE GEORGES</b>		10c. CITY, TOWN OR LOCATION <b>TEMPLE HILLS</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>5201 Edgemere Court</b>			10f. ZIP CODE <b>20748</b>		10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>STOCK CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>LIQUEUR STORE</b>	
17. FATHER'S NAME (First, Middle, Last) <b>OSCAR LINDSAY</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARTHA ELLIS</b>		
19a. INFORMANT'S NAME (Type/Print) <b>DOVIE GOLDEN (DAUGHTER)</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>719 Audrey Lane #TT-1, Oxon Hill Md. 20745</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HARMONY MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>LANDOVER, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b> M859		22. NAME AND ADDRESS OF FACILITY <b>ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, SE DC 20020</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sudden</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					Approximate interval between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>			29c. LICENSE NUMBER <b>D12879</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 14, 1991</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILSON VALLE, MD 10701 TROTTON DR, LARGO, MD 20772</b>					
31. DATE FILED (Month, Day, Year) <b>JUL 22 '91</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

61 51854

91 21625

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Opal Inez Lineback				2. DATE OF DEATH MONTH 7 DAY 23 YEAR 91		3. TIME OF DEATH 8:50 A.M.	
4. SOCIAL SECURITY NUMBER 233-09-8181		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 85 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12/14/05		8. BIRTHPLACE (State or Foreign Country) March, MO	
9a. FACILITY NAME (If not institution, give street and number) Prince George's General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Cheverly		9c. COUNTY OF DEATH Prince George's	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Riverdale		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 5705 64th Avenue				10f. ZIP CODE 20737		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Arthur A. Gott				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lula Creek			
19a. INFORMANT'S NAME (Type/Print) Betty M. Burkhammer				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5705 64th Avenue, Riverdale, Maryland 20737			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Ft. Lincoln Cemetery 7/26/91		20c. LOCATION — City or Town, State Brentwood, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Paul A. Bohan</i>				22. NAME AND ADDRESS OF FACILITY Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. <i>Cardiac Arrest</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <i>Congestive heart failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF): d. _____							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____ _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Andrew Dubois</i>				29c. LICENSE NUMBER D34403		29d. DATE SIGNED (Month, Day, Year) 7/23/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Andrew Dubois 3231 Supreme Lane Bowie MD 20740							
31. DATE FILED (Month, Day, Year) JUL 26 91				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

01 51652



91 21626

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERYL LUGMAYER</b>		2. DATE OF DEATH MONTH <b>14</b> DAY <b>25</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:00A M</b>
4. SOCIAL SECURITY NUMBER <b>212-66-6707</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>59</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>April 17 32</b>	8. BIRTHPLACE (State or Foreign Country) <b>England</b>
9a. FACILITY NAME (If not institution, give street and number) <b>8500 Weimar Court</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>		9c. COUNTY OF DEATH <b>Prince George's</b>
RESIDENCE OF DECEDENT				
10a. STATE <b>Md.</b>	10b. COUNTY <b>Prince George's</b>	10c. CITY, TOWN OR LOCATION <b>Clinton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>8500 Weimar Court</b>		10f. ZIP CODE <b>20735</b>	10g. CITIZEN OF WHAT COUNTRY? <b>England</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Secretary</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Lugmayer Assoc., Inc.</b>
17. FATHER'S NAME (First, Middle, Last) <b>Percy Bailey</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unavailable</b>		
19a. INFORMANT'S NAME (Type/Print) <b>William Lugmayer</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a-10f.</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		20c. LOCATION — City or Town, State <b>Clinton, Md.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Chronic obstructive pulmonary disease</b>				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Marasmus</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. [Signature]</b>		29c. LICENSE NUMBER <b>D12879</b>	29d. DATE SIGNED (Month, Day, Year) <b>July 25, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HONSO VALLE MD, 10701 TRAFTON DR, LARGO, MD 20772</b>				
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51959

ITEMS:23 thru 28f per ME  
G-679 9/13/91 cm  
91-4143-017

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21627

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael William Lee</b>				2. DATE OF DEATH MONTH DAY YEAR <b>07 22 1991</b>		3. TIME OF DEATH <b>2:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220-02-4135</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>27</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08/03/63</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Hunts Road- in yard</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LaPlata</b>		9c. COUNTY OF DEATH <b>Charles</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Colmar Manor</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3413 39th Avenue</b>				10f. ZIP CODE <b>20722</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b> <b>12th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Lawler Painting</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Luther Lee</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Regis Lawler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Regis Lawler</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3413 39th Avenue, Colmar Manor, Maryland 20722</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Washington National Cem. 7/25/91</b>		20c. LOCATION — City or Town, State <b>Suitland, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Francis Gasch's Sons Funeral Home, PA 4739 Baltimore Ave., Hyattsville, MD 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARRHYTHMIA COMPLICATING COCAINE USE</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>in yard</b>			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input checked="" type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>FOUND: 7/22/91</b>		28b. TIME OF INJURY <b>12:30 PM</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>FOUND: YARD</b>		28d. DESCRIBE HOW INJURY OCCURED <b>UNKNOWN</b>					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>FOUND: HUNTS RD., LaPLATA, MD</b>							
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> <b>MS</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>07 22 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margaret Korell MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

18 51957

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
RITA BEATRICE LANDRY				07 30 1991				1229 M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
031-03-7388		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		74 YRS.		2-14-17		Beverly, MA			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
3719 4th Avenue				Edgewater				AA			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
MD				Anne Arundel		Edgewater				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
3719 4th Avenue				21037				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2				Directory Supervisor				C & P. Telephone Co.			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Joseph A. Robichav				Bridget Sheehan							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Michael F. Landry				3719 4th Avenue, Edgewater, MD 21037							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Metro Crematory		Baltimore, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
				Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD 21401							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Cardiac Failure											
DUE TO (OR AS A CONSEQUENCE OF):											
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
Organic Brain Syndrome								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
Peripheral Vascular Disease								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Right Leg Amputation								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)								29c. LICENSE NUMBER			
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								D 06054			
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29d. DATE SIGNED (Month, Day, Year)			
29b. SIGNATURE AND TITLE OF CERTIFIER								7-30-1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
William P. Jones, M.D. P.O. Box 99 Lothian, Md. 20711											
31. DATE FILED (Month, Day, Year)								32. REGISTRAR'S SIGNATURE			
AUG 01 1991											

at 51658

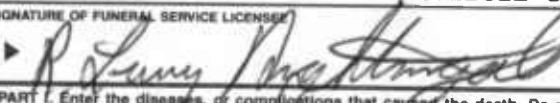
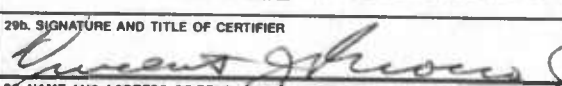
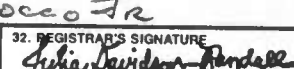
**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21629

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Grover Donald Lare</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>25</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1405</b>									
4. SOCIAL SECURITY NUMBER <b>178-16-7523</b>				5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>12-01-1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Carroll County General Hospital</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>				9c. COUNTY OF DEATH <b>Carroll</b>					
RESIDENCE OF DECEDENT																	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Carroll</b>				10c. CITY, TOWN OR LOCATION <b>Hampstead</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>3904 Shiloh Avenue</b>						10f. ZIP CODE <b>21074</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMY FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Westinghouse Corp.</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Grover L. Lare</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Homerzelle Donaldson</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Margery Ayers</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1364 First Street, Hampstead, Md. 21074</b>									
20a. MANNER OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Services 7-29</b>				DATE <b>Hampstead, Md. 21074</b>		20c. LOCATION — City or Town, State <b>Hampstead, Md. 21074</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 								22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home</b> <b>934 S. Main Street, Hampstead, Md. 21074</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. RUPTURED ANEURYSM OF ASCENDING AORTA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. HYPERTENSIVE CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>																Approximate interval between Onset and Death <b>IMMED.</b> <b>YEARS</b> <b>"</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  <div>24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO</div> <div>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO</div>																	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)								28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																	
29b. SIGNATURE AND TITLE OF CERTIFIER 								29c. LICENSE NUMBER <b>DO 1663</b>				29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 20) (Type, Print) <b>VINCENT J. Fiocco Jr.</b> <b>8 ANCHOR ST</b> <b>WESTMINSTER MD 21157</b>																	
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE 													

at 5155a

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21630							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEASED'S NAME (First, Middle, Last) DEANNE P.				2. DATE OF DEATH MONTH 7 DAY 23 YEAR 91				3. TIME OF DEATH 2005 M							
4. SOCIAL SECURITY NUMBER 221-28-1992		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 46 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12-30-1944		8. BIRTHPLACE (State or Foreign Country) De.									
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY				9c. COUNTY OF DEATH WICOMICO							
10a. STATE Md.				10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER William St.				10f. ZIP CODE 21801		10g. CITIZEN OF WHAT COUNTRY? USA									
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 3				15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Nurse		15b. KIND OF BUSINESS/INDUSTRY Hospital									
17. FATHER'S NAME (First, Middle, Last) Reese Parker, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) Pauline Webster Parker											
19a. INFORMANT'S NAME (Type/Print) Pauline W. Parker				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt2 Box 342 Delmar, De. 19940											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Eastern Shore Crematorium 7-25		20c. LOCATION — City or Town, State Georgetown, De.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Shoff</i>				22. NAME AND ADDRESS OF FACILITY Short Windsor Disharoon Funeral Home, Inc. P.O. Box 678 Laurel, De. 19956											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cerebral Liver Disease</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Chronic Alcoholism</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Ascites</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER D29105		29d. DATE SIGNED (Month, Day, Year) 7/24/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Christian Huddleston 103601st St. Freetland, Md 21824															
31. DATE FILED (Month, Day, Year) JUL 26 91				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>											

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1948

91 21631

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY E. LUTHER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1991</b>				3. TIME OF DEATH <b>7:05 PM</b>	
4. SOCIAL SECURITY NUMBER <b>220-09-8576</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>JULY 12, 1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>TENNESSEE</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>	
9c. COUNTY OF DEATH <b>St. Mary's</b>				10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ST. MARY'S</b>	
10c. CITY, TOWN OR LOCATION <b>CHARLOTTE HALL</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>WARD 9B, PERRY POINT</b>	
10f. ZIP CODE <b>20622</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>3/24/41-9/15/41</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>				17. KIND OF BUSINESS/INDUSTRY <b>FEDERAL GOVERNMENT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>LARKIN HENRY LUTHER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROVIRTIE MEYERS</b>				19a. INFORMANT'S NAME (Type/Print) <b>MRS. EDITH C. ALLEN</b>	
19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4755 MECHANICSVILLE CHAPTICO RD., MECHANICSVILLE, MD. 20659</b>				20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FORT LINCOLN 8/5</b>	
20c. LOCATION — City or Town, State <b>BRENTWOOD, MARYLAND</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Bayfield Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MD. 20650</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acidosis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. chronic obstructive lung disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>d. Seizure disorder</b> <b>Dementia toxicity</b>								Approximate interval Between Onset and Death <b>12h.</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder</b> <b>Dementia toxicity</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Fenwick</i>				29c. LICENSE NUMBER <b>D01380</b>				29d. DATE SIGNED (Month, Day, Year) <b>8-2-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN F. FENWICK M.D. LEONARDTOWN, MD. 20650</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 05 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1831 10

91 21632

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>John Jenkins Lancaster, Jr.</i>				2. DATE OF DEATH MONTH DAY YEAR <i>07 30 91</i>		3. TIME OF DEATH <i>10:30 PM</i>	
4. SOCIAL SECURITY NUMBER <i>216-16-4887</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <i>68</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6/25/23</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Mercy Hospital Baltimore</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>	
9c. COUNTY OF DEATH <i>Baltimore</i>				10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>ST. MARY'S</i>	
10c. CITY, TOWN OR LOCATION <i>ST. MARY'S CITY</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>RT. #5</i>	
10f. ZIP CODE <i>20686</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>W.W.II</i>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE W</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>6</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>EXTENSION AGENT</i>		16b. KIND OF BUSINESS/INDUSTRY <i>MD. DEPT. OF AGRICULTURE</i>	
17. FATHER'S NAME (First, Middle, Last) <i>JOHN J. LANCASTER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>GENEVIEVE CLARKE</i>			
19a. INFORMANT'S NAME (Type/Print) <i>GLORIA C. LANCASTER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2401 CALVERT ST., N.W., WASHINGTON, D.C. 20008</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>TRINITY EPISCOPAL</i>		20c. LOCATION — City or Town, State <i>8/1 ST. MARY'S CITY, MD.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward M. Brinsfield</i>				22. NAME AND ADDRESS OF FACILITY <i>BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MARYLAND 20650</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause in each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. Thomas MD</i>				29c. LICENSE NUMBER <i>D31230</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/30/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mercy Hospital</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 01 91</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

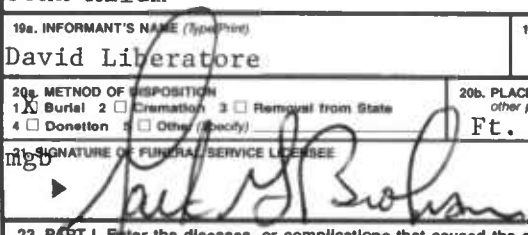


IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21633

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS AKERSON MILUM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1991</b>		3. TIME OF DEATH <b>9:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>233-12-1572</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 11, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridian Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Silver Spring</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>	
10c. CITY, TOWN OR LOCATION <b>Silver Spring</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3227 Bel Pre Road</b>	
10f. ZIP CODE <b>20906</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1929-1936</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>NO</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>-----</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>property Management</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Milum</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Blankenship</b>			
19a. INFORMANT'S NAME (Type Print) <b>David Liberatore</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6821 Jefferson St., N.E., Fridley, Minnesota 55432</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>mg</b>				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft. Lincoln Cemetery</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>FRANCIS GASCH'S SONS FUNERAL HOME, P.A. 4739 BALT. AVE., HYATTSVILLE, MD. 20781</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Pulmonary failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Chronic obstructive pulmonary disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <b>3 days.</b> <b>years.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>J.S. Bowers, M.D.</b>				29c. LICENSE NUMBER <b>DO 4418</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/19/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				32. REGISTRAR'S SIGNATURE  <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

7 (IVA)



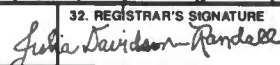
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91 21634

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Carolyn Louise McCallum				2. DATE OF DEATH MONTH DAY YEAR July 23, 1991		3. TIME OF DEATH 7:00 A M	
4. SOCIAL SECURITY NUMBER 577-22-3111		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 84 YRS.		7. DATE OF BIRTH (Month, Day, Year) October 14, 1906	
8. BIRTHPLACE (State or Foreign Country) Washington, DC				9a. FACILITY NAME (If not institution, give street and number) 8011 Steve Drive		9b. CITY, TOWN OR LOCATION OF DEATH Forestville	
9c. COUNTY OF DEATH Prince Georges				10a. STATE Maryland		10b. COUNTY Prince Georges	
10c. CITY, TOWN OR LOCATION Forestville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 8011 Steve Drive	
10f. ZIP CODE 20747				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Personnel Specialist		16b. KIND OF BUSINESS/INDUSTRY Federal Government	
17. FATHER'S NAME (First, Middle, Last) Charles Howard Miller				18. MOTHER'S NAME (First, Middle, Maiden Surname) Louise Bessler			
19a. INFORMANT'S NAME (Type/Print) Mary L. Louviere				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8011 Steve Drive Forestville, Md. 20747			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Mount Olivet Cemetery 7-25-91		20c. LOCATION — City or Town, State Washington, D.C.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY George P. Kalas Funeral Home 6160 Oxon Hill Rd. Oxon Hill, Md. 20745			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dehydration Malnutrition DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. ARTERIO-SCLEROSIS DISEASE DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D14507		29d. DATE SIGNED (Month, Day, Year) 7/23/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert D. Gerwin, M.D. 7500 Hanover Pkwy Greenbelt, Md.							
31. DATE FILED (Month, Day, Year) JUL 25 '91				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 51934

BOND

BOND

91-4077-033

91 21635

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) UNKNOWN <b>JOHNNY MARCUS MILLER</b> <i>John (91-130) Miller</i>		2. DATE OF DEATH MONTH DAY YEAR 07 19 1991		3. TIME OF DEATH 06:55 A M	
4. SOCIAL SECURITY NUMBER 568-02-3929		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 19 YRS.	
7. DATE OF BIRTH (Month, Day, Year) December 29, 1971		8. BIRTHPLACE (State or Foreign Country) Washington, D.C.			
9a. FACILITY NAME (If not institution, give street and number) 9905 CALTOR LANE			9b. CITY, TOWN OR LOCATION OF DEATH OXON HILL		9c. COUNTY OF DEATH PRINCE GEORGE
10a. STATE Maryland		10b. COUNTY Prince Georges		10c. CITY, TOWN OR LOCATION Forestville	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 2917 Parkland Drive			10f. ZIP CODE 20747		10g. CITIZEN OF WHAT COUNTRY? United States
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: Black					
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th grade		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) High School Student		16b. KIND OF BUSINESS/INDUSTRY Education	
17. FATHER'S NAME (First, Middle, Last) Haywood C Miller		18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie Patricia Sherard			
19a. INFORMANT'S NAME (Type/Print) Haywood C. & Annie P. Miller		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2917 Parkland Drive, Forestville, Maryland 20747			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Washington National Cemetery		20c. LOCATION — City or Town, State Suitland, Maryland	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John W. Latney Jr.</i>		22. NAME AND ADDRESS OF FACILITY Latney's Funeral Home 3831 Georgia Avenue, N.W.; Wash. D.C. 20011			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		<i>Multiple gunshot wounds</i> DUE TO (OR AS A CONSEQUENCE OF):			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) BURGLARY SCENE			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 07 19 1991		28b. TIME OF INJURY 06:47A M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED SUBJECT SHOT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 990 CALTOR LANE		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) OXON HILL, MARYLAND			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 07 19 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A.M. Dixon 111 PENN STREET BALTIMORE, MARYLAND 21201					
31. DATE FILED (Month, Day, Year) JUL 26 '91		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Joanne Moore</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>19</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:50 AM</b>	
4. SOCIAL SECURITY NUMBER <b>327-14-7839</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>01 25 21</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Illinois</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7308 Wessex Drive</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Camp Springs</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Camp Springs</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7308 Wessex Drive</b>	
10f. ZIP CODE <b>20748</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert Wilson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edna Pold</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William P. Moore</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10 A-F</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington National Cemetery</b>		20c. LOCATION — City or Town, State <b>Arlington Virginia</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph Butler Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Rd., Clinton, Md.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. cardiopulmonary arrest due to</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. widely metastatic Stage IV endstage</b> <b>c. ovarian carcinoma</b> <b>d.</b>							Approximate Interval Between Onset and Death <b>2 1/2 years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David P. Hyman MD</i>				29c. LICENSE NUMBER <b>ME0056732</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 20, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>National Naval Medical Center, Bethesda, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES L. MOSBY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7-23-91</b>		3. TIME OF DEATH <b>12:30 A</b>	
4. SOCIAL SECURITY NUMBER <b>214 03 9693</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 11, 1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>West Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>So. Maryland Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>	
9c. COUNTY OF DEATH <b>Prince George's</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Capitol Heights</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6712 Hastings Drive</b>	
10f. ZIP CODE <b>20743</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>Off</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Set Printer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Govt</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Mosby</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Columbia Winston</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Eloise Gray</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6712 Hastings Drive Capitol Hts., MD 20743</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 7-27</b>		20c. LOCATION — City or Town, State <b>Landover, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Jimmy G. Neal Sr.</b>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of the large intestine</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Due to (or as a consequence of):</b> <b>metastases to the lungs, abdomen.</b> b. <b>Due to (or as a consequence of):</b> <b>Gravid uterine bleeding.</b> c. <b>Due to (or as a consequence of):</b> <b>Carcinoma of the prostate.</b> d. <b>Due to (or as a consequence of):</b> <b>metastases to the brain.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>metastases to the brain</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D20824</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Cherry R. (Jennison) 9450 Penn. Ave. #18 Upper Meriden</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall MD, 20772</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. This certificate has been signed by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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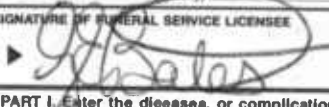
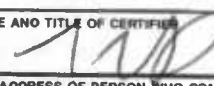
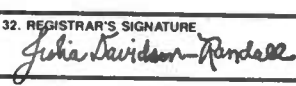


TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21638

1. DECEDENT'S NAME (First, Middle, Last) <b>Dorothy Ann MULCAHEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 25, 1991</b>		3. TIME OF DEATH <b>0459</b> M							
4. SOCIAL SECURITY NUMBER <b>217-28-8062</b>		5. SEX 1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7 - 14 - 24</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Calvert Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Prince Frederick</b>				9c. COUNTY OF DEATH <b>Calvert</b>					
10a. STATE <b>Md.</b>		10b. COUNTY <b>Calvert</b>		10c. CITY, TOWN OR LOCATION <b>Lusby</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>661 San Juan Court</b>				10f. ZIP CODE <b>20657</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>									
17. FATHER'S NAME (First, Middle, Last) <b>William H. Irwin</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Aileen Davis</b>									
19a. INFORMANT'S NAME (Type/Print) <b>James J. Mulcahey, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a-10f.</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Md. State Veterans Cem. 7-29-91</b>		20c. LOCATION — City or Town, State <b>Cheltenham, Md.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Lee Funeral Home, Inc. 6633 Old Alexander Ferry Road Clinton, Md. 20735</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Metastatic Colon Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D33123</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-25-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Prince Frederick, Maryland 20678</b>													
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>				32. REGISTRAR'S SIGNATURE 									

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 21639

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Raymond H. Monica</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10 PM</b> <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>577-05-0270</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 24, 1910</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Charleston, SC</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>2602 Dawson Ave.,</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Wheaton</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Wheaton</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2602 Dawson Avenue</b>				10f. ZIP CODE <b>20902</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Shift Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pepco Electric/Utility</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Max Monica</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elenora Kowaleski</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edna Monica</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2602 Dawson Avenue, Wheaton, MD 20902</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Crematory 7/25/91</b>		20c. LOCATION — City or Town, State <b>Brentwood, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>T. Gawn Jr. M00853</b>				22. NAME AND ADDRESS OF FACILITY <b>Fort Lincoln Funeral Home, Inc. 3401 Bladensburg Rd., Brentwood, MD 20722</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Chronic Obstructive Pulmonary Emphysema 20 years</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Bronchogenic Carcinoma</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <b>Robert C. Macon M.D.</b>				29b. LICENSE NUMBER <b>D06945</b>		29c. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Robert C. Macon, M.D. 809 Viers Mill Road Rockville, Maryland 20850</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21640

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MAUDE R. Marshall				2. DATE OF DEATH MONTH DAY YEAR July 22 1991		3. TIME OF DEATH 0400 M	
4. SOCIAL SECURITY NUMBER 229-09-7768		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 86 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 21, 1904	
8. BIRTHPLACE (State or Foreign Country) VIRGINIA				9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY	
9c. COUNTY OF DEATH WICOMICO							
10a. STATE VIRGINIA		10b. COUNTY ACCOMACK COUNTY		10c. CITY, TOWN OR LOCATION WELLES-WHARF- ATLANTIC		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE 23303		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 yr		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY NONE			
17. FATHER'S NAME (First, Middle, Last) HENRY RIGGEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) CLARISSA MOORE			
19a. INFORMANT'S NAME (Type/Print) JAMES MARSHALL				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) LANKFORD HIGHWAY, TEMPERANCEVILLE, VA 23442			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BOWLING CEME, OAK HALL, VA 8/7/24/91		20c. LOCATION — City or Town, State OAK HALL, VA		20d. DATE 8/7/24/91	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James N. Fox				22. NAME AND ADDRESS OF FACILITY FOX FUNERAL HOME LANKFORD HIGHWAY, TEMPERANCEVILLE, VA 23442			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Cardiac Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Infarcted Cardiovascular Disease</u> DUE TO (OR AS A CONSEQUENCE OF): d. Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Respiratory Pneumonia</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER James H. Clifford MD				29c. LICENSE NUMBER D01969		29d. DATE SIGNED (Month, Day, Year) 7/22/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) JAMES H. CLIFFORD MD, 1212 Medical Center, Salisbury, MD 21801							
31. DATE FILED (Month, Day, Year) JUL 29 '91		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21641

91-4268-019

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANK RAY MORRIS</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:45P M</b>	
4. SOCIAL SECURITY NUMBER <b>236-34-8286</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>07/16/1924</b>	
8. FACILITY NAME (If not institution, give street and number) <b>HOME-622 RACE STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CAMBRIDGE</b>		9c. COUNTY OF DEATH <b>DORCHESTER</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>DORCHESTER</b>		10c. CITY, TOWN OR LOCATION <b>CAMBRIDGE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>622 RACE STREET</b>		10f. ZIP CODE <b>21613</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE/CAUC.</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (1-4 or 5+) <b>NOT EMPLOYED</b>	
16. KIND OF BUSINESS/INDUSTRY <b>NONE</b>				17. FATHER'S NAME (First, Middle, Last) <b>FRANK RAY MORRIS, SR.</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY ANNETTA THOMAS</b>	
19a. INFORMANT'S NAME (Type/Print) <b>MRS. HAZEL E. THOMPSON (AUNT)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>71 N. FOREST RD., APT. C, SONORA, CALIFORNIA 95370</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SALISBURY CREMATORY</b>		20c. LOCATION — City or Town, State <b>1991 SALISBURY, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alfred Burren-Brown</i>				22. NAME AND ADDRESS OF FACILITY <b>CURRAN FUNERAL HOME 308 HIGH STREET, CAMBRIDGE, MD. 21613</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>Inquiry</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario Golle</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>07 25 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. MARIO GOLLE 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>Carson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH-16 Rev 1/89





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be retained by the funeral director.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21642							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <i>Mary Moore</i>				2. DATE OF DEATH MONTH <i>7</i> DAY <i>20</i> YEAR <i>91</i>				3. TIME OF DEATH <i>5:00 am</i> M							
4. SOCIAL SECURITY NUMBER <i>266-44-4861</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>77</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>2-26-14</i>		8. BIRTHPLACE (State or Foreign Country) <i>BUTTS COUNTY</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>WATERVIEW</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>SALISBURY</i>				9c. COUNTY OF DEATH <i>WICOMICO</i>							
RESIDENCE OF DECEDENT															
10a. STATE <i>MD.</i>		10b. COUNTY <i>WICOMICO</i>		10c. CITY, TOWN OR LOCATION <i>SALISBURY</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <i>1807 KOWEN</i>				10f. ZIP CODE <i>21801</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>3rd</i> College (1-4 or 5+) <i></i>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>LABORER</i>				18b. KIND OF BUSINESS/INDUSTRY <i>FARM WORK</i>							
17. FATHER'S NAME (First, Middle, Last) <i>WILLIE TAYLOR</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ALBERTA GREENE</i>											
19a. INFORMANT'S NAME (Type/Print) <i>BEATRICE FOUNTAIN</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>ADDRESS SAME AS ABOVE</i>											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>SALISBURY CREMATORY</i>		20c. LOCATION — City or Town, State <i>SNOWHILL RD. SALIS. MD.</i>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Loretta B. Jolley</i>				22. NAME AND ADDRESS OF FACILITY <i>JOLLEY MEMORIAL CHAPEL, RTE. 2, BOX 920 SALISBURY, MD. 21801</i>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>COPD.</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <i></i> DUE TO (OR AS A CONSEQUENCE OF): b. <i></i> DUE TO (OR AS A CONSEQUENCE OF): c. <i></i> DUE TO (OR AS A CONSEQUENCE OF): d. <i></i>										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Recurrent UTI</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER <i>C. Addison, M.D.</i>		29c. LICENSE NUMBER <i>D29105</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/24/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Polaku St. Fruitland Md 21801</i>															
31. DATE FILED (Month, Day, Year) <i>JUL 26 '91</i>		32. REGISTRAR'S SIGNATURE <i>John B. ...</i>													

21 STOPS

10-11-11

91-4457-037

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21643

1. DECEDENT'S NAME (First, Middle, Last) <b>Frances Leona Morgan</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 01 1991</b>				3. TIME OF DEATH <b>5:00 P M</b>			
4. SOCIAL SECURITY NUMBER <b>214-24-0931</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 7, 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>308 SWANEE PLACE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Lexington Park</b>				9c. COUNTY OF DEATH <b>St. Mary's</b>			
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S</b>		10c. CITY, TOWN OR LOCATION <b>LEXINGTON PARK</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>308 SWANEE PLACE</b>				10f. ZIP CODE <b>20653</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11TH GRADE</b> College (1-4 or 5+) <b>HOUSEWIFE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE RAYMOND WHALEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HELEN MORGAN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MARY A. TURNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>308 LIBERTY ST., LEXINGTON PARK, MD. 20653</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. MARK'S UAME CEMETERY 8/06/91</b>				20c. LOCATION — City or Town, State <b>VALLEY LEE, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerosis cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>Chronic alcoholism</b>								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic alcoholism</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>HEAD ONLY</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ann M. Dixon</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>08 02 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann M. Dixon, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 05 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES WILLIAM MILLER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 31, 1991</b>		3. TIME OF DEATH <b>5:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>184-22-0141</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>61</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 5, 1930</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>PHYSICIANS MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>LA PLATA</b>		9c. COUNTY OF DEATH <b>CHARLES</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ST. MARY'S</b>		10c. CITY, TOWN OR LOCATION <b>LEXINGTON PARK</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>406 ESSEX DRIVE</b>				10f. ZIP CODE <b>20653</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES <b>1948-1953</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ENGINEER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ELECTRONICS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES ALEXANDER MILLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DOROTHEA EATON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. JOAN C. MILLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>406 ESSEX DRIVE, LEXINGTON PARK, MD. 20653</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHARLES MEMORIAL GARDENS</b>		20c. LOCATION — City or Town, State <b>LEONARDTOWN, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward N. Buford Jr.</i>		22. NAME AND ADDRESS OF FACILITY <b>BRINSFIELD FUNERAL HOME, P.A. P.O. BOX 279, LEONARDTOWN, MD. 20650</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Adenocarcinoma of Lung</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <i>Hypertension</i> <i>Maternal Chronic Obstructive Pulmonary Disease</i> <i>Smoking</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>George H. Wathen M.D.</i>		29c. LICENSE NUMBER <b>D--20629</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/31/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GEORGE H. WATHEN M.D. PEMBROOKE SQUARE, SUITE 105 HIGHWAY 301 SOUTH 20603</b>		31. DATE FILED (Month, Day, Year) <b>AUG 02 91</b>					
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSEMARY (NMN) MORGAN, 1				2. DATE OF DEATH MONTH DAY YEAR JULY 29, 1991		3. TIME OF DEATH 5:54 P.M.	
4. SOCIAL SECURITY NUMBER 220-78-6082		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 7, 1921	
9a. FACILITY NAME (If not institution, give street and number) NAVAL HOSPITAL RESIDENCE OF DECEDENT				9b. CITY, TOWN OR LOCATION OF DEATH PATUXENT RIVER		9c. COUNTY OF DEATH ST. MARY'S	
10a. STATE MARYLAND		10b. COUNTY ST. MARY'S		10c. CITY, TOWN OR LOCATION LEXINGTON PARK		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 407 LIBERTY ST.				10f. ZIP CODE 20653		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5TH. GRADE		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY HOME			
17. FATHER'S NAME (First, Middle, Last) UNKNOWN				18. MOTHER'S NAME (First, Middle, Maiden Surname) CATHERINE HOLLAND			
19a. INFORMANT'S NAME (Type/Print) SADIE L. MORGAN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 407 LIBERTY ST., LEXINGTON PARK, MD. 20653			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. MARK'S UAME		DATE 8/03/91		20c. LOCATION — City or Town, State VALLEY LEE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael L. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Probable Myocardial Infarction</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Cerebrovascular disease &amp; stroke</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 6 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wm Boyd</i>				29c. LICENSE NUMBER D14285		29d. DATE SIGNED (Month, Day, Year) 7/30/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) WILLIAM D. BOYD, II. M.D. LEONARDTOWN, MARYLAND 20650							
31. DATE FILED (Month, Day, Year) AUG 02 '91		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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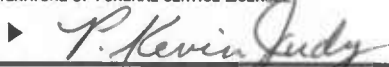
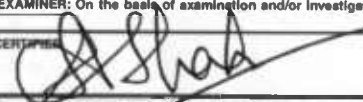
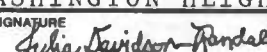
BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146.

**TO THE HOSPITAL OR ATTENDING PHYSICIAN:** The law requires that the death certificate be executed within \_\_\_\_\_ hours after death. Page 6 may be retained by the hospital or attending physician.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID FORNEY MYERLY</b>		2. DATE OF DEATH MONTH <b>JULY</b> DAY <b>30</b> YEAR <b>1991</b>		3. TIME OF DEATH	
4. SOCIAL SECURITY NUMBER <b>214-03-4639</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.	
9a. FACILITY NAME (If not institution, give street and number) <b>10 FREDERICK STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TANEYTOWN</b>		9c. COUNTY OF DEATH <b>CARROLL</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>TANEYTOWN</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10 FREDERICK STREET</b>		10f. ZIP CODE <b>21787</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>CAUCASIAN</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9thb</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UPHOLSTERER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ANTIQUE RESTORATION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>ELIAS ROY MYERLY</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CARRIE ROSELLA FORNEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>FLORENCE C. NUSBAUM</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10 FREDERICK STREET TANEYTOWN, MD 21787</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>TRINITY LUTHERAN CEMETERY</b>		20c. LOCATION — City or Town, State <b>TANEYTOWN, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>136 EAST BALTIMORE ST SKILES FUNERAL HOME TANEYTOWN, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Lung Cancer</b>  Sequitentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____				Approximate Interval Between Onset and Death <b>6 months</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D-36147</b>		29d. DATE SIGNED (Month, Day, Year) <b>JULY 30, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SATISH SHAH, M.D., 217 WASHINGTON HEIGHTS WESTMINSTER, MARYLAND 21157</b>					
31. DATE FILED (Month, Day, Year) <b>7/30/91 JUL 30 '91</b>		32. REGISTRAR'S SIGNATURE 			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Virginia Mudd</i>		2. DATE OF DEATH MONTH <i>7</i> DAY <i>29</i> YEAR <i>91</i>		3. TIME OF DEATH <i>3:45 A M</i>	
4. SOCIAL SECURITY NUMBER <i>213-38-1153</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>83</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>10-15-07</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Meridian Nursing Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>LA PLATA, Md.</i>		9c. COUNTY OF DEATH <i>Charles</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Charles</i>		10c. CITY, TOWN OR LOCATION <i>Rt. 2 Box 185 Pomfret, Md.</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>Rt. 2 Box 185 Pomfret, Md.</i>		10f. ZIP CODE <i>20675</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>4</i>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Teacher</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Education</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Jeremiah Theodore Mudd</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Mary Mudd Mudd</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Robert J. Mudd, Sr.</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>P. O. Box 36, Pomfret, Md. 20675</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Mary's Cemetery</i>		20c. LOCATION — City or Town, State <i>Bryantown, Maryland</i>	
21. SIGNATURE OF FUNERAL HOME LICENSEE <i>Michael Blankenship</i>		22. NAME AND ADDRESS OF FACILITY <i>Huntt Funeral Home P. O. Box 156, Waldorf, Md. 20604-0156</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Pneumonia</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Sepsis</i> c. <i>Urinary Tract Infection</i> d. <i>Anemia</i>					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Atrial Fibrillation, Organic brain syndrome, Parkinson's Disease, Coronary artery disease, arteriosclerosis</i>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					29b. SIGNATURE AND TITLE OF CERTIFIER <i>James M. [Signature]</i>
29c. LICENSE NUMBER <i>D08370</i>					29d. DATE SIGNED (Month, Day, Year) <i>7/29/91</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
31. DATE FILED (Month, Day, Year) <i>JUL 31 '91</i>		32. REGISTRAR'S SIGNATURE <i>Gloria Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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18

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21648

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) RICHARD STEPHEN MAY				2. DATE OF DEATH MONTH DAY YEAR 07 28 91		3. TIME OF DEATH 2:00A			
4. SOCIAL SECURITY NUMBER 212-54-8460		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 41 YRS.		7. DATE OF BIRTH (Month, Day, Year) SEPT 14 1949		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) SACRED HEART HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CUMBERLAND			9c. COUNTY OF DEATH ALLEGANY		
10a. STATE MARYLAND				10b. COUNTY ALLEGANY		10c. CITY, TOWN OR LOCATION CUMBERLAND		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 18 GREENE STREET				10f. ZIP CODE 21502		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 5				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ART INSTRUCTOR			16b. KIND OF BUSINESS/INDUSTRY SCHOOL TEACHER		
17. FATHER'S NAME (First, Middle, Last) HARVEY W. MAY, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS E. KOELKER					
19a. INFORMANT'S NAME (Type/Print) HARVEY W. MAY, JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 103 BROWNE AVE CUMBERLAND MARYLAND 21502					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) REST LAWN MEMORIAL PARK JULY 30 1991 LAVALE MARYLAND		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dale L. Merritt				22. NAME AND ADDRESS OF FACILITY SILCOX-MERRITT FUNERAL HOME 404 DECATUR STREET CUMBERLAND MARYLAND					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>ARDS</u> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>HIV positive</u>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Vik Poonai, M.D.		29c. LICENSE NUMBER D-36766		29d. DATE SIGNED (Month, Day, Year) July 28, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) VIK POONAI, M.D. 715 WILLIAMS STREET CUMBERLAND, MD. 21502									
31. DATE FILED (Month, Day, Year) JUL 30 1991		32. REGISTRAR'S SIGNATURE Gerald Davidson-Randall							

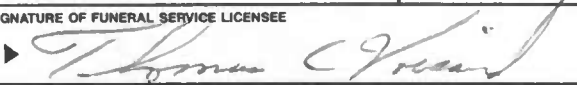

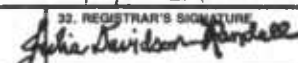
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WOTTONS OF COTTON

91 21649

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Helen M. McCloskey</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>25</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:35 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>165-09-3947</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 19, 1902</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Ireland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>PA NJ</b>		10b. COUNTY <b>Phila. Gloucester</b>	
10c. CITY, TOWN OR LOCATION <b>Phila. Mullica Hill</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>405 Acker Street</b>	
10f. ZIP CODE <b>19126 08062</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Office Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Oil</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Campbell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ann Campbell</b>			
19a. INDEEDMANT'S NAME (Type Print) <b>Joseph Carroll McCloskey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>101 Holly Court, Mullica Hill, NJ 08062</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Sepulchre Cemetery</b>		20c. LOCATION — City or Town, State <b>Wyndmoor, PA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Starrings Funeral Home 3111 Mountain Rd., Pasadena, MD 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Hemelobopathy</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>b. Mucosis Fungoides</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c. OUE TO (OR AS A CONSEQUENCE OF):</b>  <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>TUNNINELO PAOLA ST. AGNES HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NAOMI EDITH MARCOOT</b>		2. DATE OF DEATH MONTH DAY YEAR <b>July 29, 1991</b>		3. TIME OF DEATH <b>0620</b> M	
4. SOCIAL SECURITY NUMBER <b>216-16-4449</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 17, 1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Annapolis</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1012 Monroe Street</b>		10f. ZIP CODE <b>21403</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>		17. FATHER'S NAME (First, Middle, Last) <b>Harry C. Brown</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carvilla Perkins</b>		19a. INFORMANT'S NAME (Type/Print) <b>Ralph Michael Marcoot</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18107 Carrisa Way, Olney, MD 20832</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Cemetery</b>		20c. LOCATION — City or Town, State <b>Annapolis, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jeffrey L. Taylor</i>		22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Ca Pancreas</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Lapenta MD</i>		29c. LICENSE NUMBER <b>D21438</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL J. LAPENTA 600 RIDGLEY AVE, #120, ANNAPOLIS MD 21401</b>		31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>	
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

02019 19

FOR Leona Marks  
1 - STATE REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21651

1. DECEDENT'S NAME (First, Middle, Last) <b>LEONA V. MARKS</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:25 P M</b>	
4. SOCIAL SECURITY NUMBER <b>364-42-1206</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>90</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-23-10</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Salisbury Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>WORCESTER</b>		10c. CITY, TOWN OR LOCATION <b>OCEAN CITY</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>13806 FOUNTAIN ROAD</b>			
10f. ZIP CODE <b>21842</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 YEARS</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE EDGAR CAVANAGH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RENA BELLE LESSA</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GARRETT MARKS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>HARTFORD COUNTY, MARYLAND</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OTTAWA PARK CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>CLARKSTON, MICHIGAN</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD. SALISBURY, MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Acute pneumonia</b> <b>metastatic Breast Cancer</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b> <b>Due to (or as a consequence of):</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>039813</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/27/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael ATKINS, 1104 Heathway Dr, Salisbury Md.</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

at 1221

1221

1221

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21652

1. DECEDENT'S NAME (First, Middle, Last) Rudolph Garfield Mitchell		2. DATE OF DEATH MONTH DAY YEAR July 20 1991		3. TIME OF DEATH 2003 M	
4. SOCIAL SECURITY NUMBER 220-52-0770		5. SEX M <input checked="" type="checkbox"/> F <input type="checkbox"/>		6. AGE (In yrs. last birthday) 41 YRS.	
7. DATE OF BIRTH (Month, Day, Year) 2-11-1950		8. BIRTHPLACE (State or Foreign Country) Wicomico		9. COUNTY OF DEATH WICOMICO	
9a. FACILITY NAME (If not institution, give street and number) PENINSULA GENERAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH SALISBURY		9c. COUNTY OF DEATH WICOMICO	
10a. STATE Maryland		10b. COUNTY Wicomico		10c. CITY, TOWN OR LOCATION Salisbury	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 825 West Rd.		10f. ZIP CODE 21801	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Vietnam	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 2+	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Laborer		16b. KIND OF BUSINESS/INDUSTRY None		17. FATHER'S NAME (First, Middle, Last) Charles Andrew Mitchell	
18. MOTHER'S NAME (First, Middle, Maiden Surname) Bethenia Golden		19a. INFORMANT'S NAME (Type/Print) Charles Andrew Mitchell Jr.		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Leader Dr. Newark De, 19713	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Head Of Creek		20c. LOCATION — City or Town, State Head Of Creek	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Bladys B. Stewart		22. NAME AND ADDRESS OF FACILITY 821 West Rd. Clinton F. Stewart-Salis. Md. 21801		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → upper gastrointestinal hemorrhage Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { acute + chronic alcohol abuse malnutrition coagulopathy	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Shawn G. Linnaman MD		29c. LICENSE NUMBER D36809	
29d. DATE SIGNED (Month, Day, Year) 7/21/91		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 306 Kay Avenue, Salisbury MD 21801		31. DATE FILED (Month, Day, Year) JUL 24 91	

51 51225

*Handwritten signature*

18 35 36

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21653			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES NORRIS SR. M.N. (GODFREY)</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>28</b> YEAR <b>91</b>				3. TIME OF DEATH <b>6<sup>10</sup> A M</b>			
4. SOCIAL SECURITY NUMBER <b>213-01-5012</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-3-1909</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>LONG VIEW NURSING HOME</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>MANCHESTER</b>				9c. COUNTY OF DEATH <b>CARROLL</b>			
10a. STATE <b>MD.</b>		10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>WESTMINSTER</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2363 TYRONE Rd.</b>				10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th grade</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>EXPEDITOR</b>		16a. KIND OF BUSINESS/INDUSTRY <b>CAN+BOTTLE MANUFACTURING</b>							
17. FATHER'S NAME (First, Middle, Last) <b>John Norris</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith (MAIDEN NAME - UNKNOWN)</b>							
19a. INFORMANT'S NAME (Type/Print) <b>JAMES NORRIS JR.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2520 FAIRMOUNT Rd. HAMPSHIRE, MD. 21074</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CARROLL CREMATORY</b>		20c. LOCATION — City or Town, State <b>HAMPSHIRE, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert A. Myers</b>				22. NAME AND ADDRESS OF FACILITY <b>MYERS FUNERAL HOME WESTMINSTER, MD.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Symphyseal</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Heart Failure</b>								Approximate Interval Between Onset and Death <b>3 years</b>			
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>MD</b>				29c. LICENSE NUMBER <b>D33165</b>				29d. DATE SIGNED (Month, Day, Year) <b>7/28/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Steven Shaffer 2111 Harrow Pk. Hampshire Md 21074</b>											
31. DATE FILED (Month, Day, Year) <b>JUL 30 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>BEVERLY ANN NORRIS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 24, 1991</b>		3. TIME OF DEATH <b>3:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-36-8413</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>51</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-2-40</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>LaVale</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>18 Warfield Place</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Engineer-Contractor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B &amp; N Builders &amp; Pools</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Ralph G. Cover</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Mae Bell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles F. Norris</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>18 Warfield Place, LaVale, MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 7-28</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD 21502</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert C. Adams</i>				22. NAME AND ADDRESS OF FACILITY <b>Silcox-Merritt Funeral Service 404 Decatur St., Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Breast carcinoma metastasis to</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Bone, lung, pleura + Stomach</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Sagin MD</i>				29c. LICENSE NUMBER <b>D 35481</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>Dr. M. Sagin, Memorial Hospital, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 1991</b>				32. REGISTRAR'S SIGNATURE <i>Joella Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 should be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Leonard Irving Nichols				2. DATE OF DEATH MONTH DAY YEAR 07-28-91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 706-01-0396		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 85 YRS.		7. DATE OF BIRTH MONTH DAY YEAR 04-09-06	
8. BIRTHPLACE (State or Foreign Country) Massachusetts							
9a. FACILITY NAME (If not institution, give street and number) 700 American Drive, Apt. 54				9b. CITY, TOWN OR LOCATION OF DEATH Annapolis		9c. COUNTY OF DEATH Anne Arundel	
10a. STATE MD				10b. COUNTY Anne Arundel		10c. CITY, TOWN OR LOCATION Annapolis	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER 700 American Drive, Apt. 54				10f. ZIP CODE 21403		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Supervisor Transportation		16b. KIND OF BUSINESS/INDUSTRY U. S. Government			
17. FATHER'S NAME (First, Middle, Last) Louis Nichols				18. MOTHER'S NAME (First, Middle, Maiden Surname) Annie E. McTeague			
19a. INFORMANT'S NAME (Type/Print) John A. Nichols				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 14 Fisk Circle, Annapolis, MD 21401			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Veterans Cemetery		20c. LOCATION — City or Town, State Crownsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Thomas A. Hardesty</i>				22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Ca prostate metastatic</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Arteriosclerosis</i> <i>Renal failure</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. LaPenta MD</i>				29c. LICENSE NUMBER D 21438		29d. DATE SIGNED (Month, Day, Year) 7/29/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) MICHAEL J. LaPENTA MD, 600 RIDGLEY AVE #120, ANNAPOLIS MD 21401							
31. DATE FILED (Month, Day, Year) JUL 30 1991				32. REGISTRAR'S SIGNATURE <i>John A. Nichols</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CLAUDE LEWIS NICHOLS, SR.</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>18</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>23:15</b> M	
4. SOCIAL SECURITY NUMBER <b>214-10-8420</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-29-1915</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1401A Glen Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
10a. STATE <b>Md.</b>				10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1401A Glen Ave.</b>			
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Refinishing &amp; Restoring Antiques</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Antiques</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Nichols</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ida M. Thompson Nichols</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1401A Glen Ave. Salisbury, Md. 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Wicomico Memorial Park</b>		20c. LOCATION — City or Town, State <b>Salisbury, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Short Jr.</i>		22. NAME AND ADDRESS OF FACILITY <b>Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic Small Cell Carcinoma of the colon</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph N. Grasso MD</i>				29c. LICENSE NUMBER <b>020507</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph N. Grasso 145 E. CARROLL St SALISBURY MD</b>							
31. DATE FILED (Month, Day, Year) <b>7/22/91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

8

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Garric Owens</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>24</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:02 PM</b>					
4. SOCIAL SECURITY NUMBER <b>579-14-8977-D</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/21/06</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Regency Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>7420 Marlboro Pike</b>				9c. COUNTY OF DEATH <b>P.G.</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>P.G.</b>		10c. CITY, TOWN OR LOCATION <b>UPPER MARLBORO</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6109 S. Crain Hwy - Upper Marlboro</b>				10f. ZIP CODE <b>20772</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>7th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>					
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM CURTIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JANIE CURTIS</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MRS. ELOISE BROWN (NIECE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6109 SOUTHWEST CRAIN HIGHWAY UPPER MARLBORO, MD. 20772</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>TRINITY EPISCOPAL CHURCH CEMETERY</b>		20c. LOCATION — City or Town, State <b>UPPER MARLBORO, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FUNERAL HOME <b>ROLLINS FUNERAL HOME, INC.</b> <b>4339 HUNT PLACE, N.E. WASH. D.C. 20019</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Cardiopulmonary Arrest - Death.</b> <b>ATTN</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Cushing's Disease</b> <b>3/PCVA.</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Malnutrition &amp; dehydration</b> <b>Cardiac Failure</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <b>OTHER:</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER <b>D 23826</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G. Edgumbe MD #100 Old Branch Ave.</b>											
31. DATE FILED (Month, Day, Year) <b>7/24/91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

72215 10



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21658

1. DECEDENT'S NAME (First, Middle, Last) <b>Adeline S Paterra</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-30-8940</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10/4/07</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Penna.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Sacred Heart Nursing Home</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Hyattsville</b>	
9c. COUNTY OF DEATH <b>Pr. George's</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Hyattsville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5712 30th Ave.</b>	
10f. ZIP CODE <b>20782</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>			
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				17. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
18. FATHER'S NAME (First, Middle, Last) <b>Francisco Santoriella</b>				19. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Vario</b>			
20. INFORMANT'S NAME (Type/Print) <b>Sara Plumer</b>				21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5712 30th Ave., Hyattsville, Md. 20782</b>			
22. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				23. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Oaklawn Cemetery</b> <b>7/25/91</b>			
24. LOCATION — City or Town, State <b>Baltimore, Md.</b>				25. NAME AND ADDRESS OF FACILITY <b>Gasch's Funeral Home 4739 Baltimore Ave., Hyattsville, Md. 20781</b>			
26. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Cardio pulmonary Arrest</b> <b>b. Pulmonary Edema</b> <b>c. Seemingly list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>d. Pneumonia</b>							
27. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pneumonia</b>							
28. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
29. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
30. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
31. HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input checked="" type="checkbox"/> OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
32. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined							
33. DATE OF INJURY (Month, Day, Year) <b>7/21/91</b>							
34. TIME OF INJURY <b>M</b>							
35. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
36. DESCRIBE HOW INJURY OCCURRED							
37. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)							
38. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
39. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
40. SIGNATURE AND TITLE OF CERTIFIER <b>S.T. [Signature]</b>							
41. LICENSE NUMBER <b>D37934</b>							
42. DATE SIGNED (Month, Day, Year) <b>7/21/91</b>							
43. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. Trifoglio, MD 7500 Greenway Center Drive Greenbelt MD 20770</b>							
44. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>							
45. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

6

91 51928

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2/3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21659

1. DECEDENT'S NAME (First, Middle, Last) <b>Mitchell L. Parker</b>		2. DATE OF DEATH MONTH <b>July</b> DAY <b>25</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1427</b> M	
4. SOCIAL SECURITY NUMBER <b>218-07-4276</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>8-2-18</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Ocean City</b>	
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO		10e. STREET AND NUMBER <b>30 Deep Channel Dr.</b>		10f. ZIP CODE <b>21811</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES <b>WW II</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Motel Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospitality</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Mitchell H. Parker</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Flora Rayne</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cecilia D. Parker</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>30 Deep Channel Dr. Berlin, Md., 21811</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dennis Cemetery 7-27</b>		20c. LOCATION — City or Town, State <b>Willards, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Ullrich Funeral Home Berlin, Md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrhythmia</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Respiratory Failure</b> <b>COPD - Severe</b>		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> ER/Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)			
27. MANNER OF DEATH <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D 20441</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Joseph Rappetto Quincy &amp; Locust Sts. Salisbury, Md.</b>			
31. DATE FILED (Month, Day, Year) <b>Aug 29 1991</b>		32. REGISTRAR'S SIGNATURE 			

at 1525

91 21660

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Marie Louise Pyzik</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>27</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>149-26-5851</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>57</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3 14 1934</b>	
8. BIRTHPLACE (State or Foreign Country) <b>NJ</b>				9a. FACILITY NAME (If not institution, give street and number) <b>741 Holiday Lane</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
9c. COUNTY OF DEATH <b>Carroll</b>				10a. STATE <b>Md</b>		10b. COUNTY <b>Carroll</b>	
10c. CITY, TOWN OR LOCATION <b>Westminster</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>741 Holiday Lane</b>	
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>housewife</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Frank Lokaj</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Katherine Lokaj</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Eugene R. Pyzik</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>741 Holiday Lane, Westminster, Md. 21157</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremations, Inc.</b>		20c. LOCATION — City or Town, State <b>Hampstead, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert K. Pritts, Sr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Pritts Funeral Home &amp; Chapel 412 Washington Rd., Westminster, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute myocardial infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>minutes</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus, CHTF</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>DOA by Police Exam.</b>				27. MANNER OF DEATH 1. <input checked="" type="checkbox"/> Natural 2. <input type="checkbox"/> Accident 3. <input type="checkbox"/> Suicide 4. <input type="checkbox"/> Homicide 5. <input type="checkbox"/> Pending Investigation 6. <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1. <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>D. S. Kalaria MD</b>		29c. LICENSE NUMBER <b>D 23015</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/28/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DINESH S. KALARIA 217, WASHINGTON HGTS, WESTMINSTER</b>					
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21661

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>OLDEN WESLEY POTTER</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>19</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:50A</b>	
4. SOCIAL SECURITY NUMBER <b>215-32-8078</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/29/36</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Harford</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Aberdeen</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>118 W. Belair Avenue</b>		10f. ZIP CODE <b>21001</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 yrs.</b> College (1-4 or 5+)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic Helper</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Automotive</b>		17. FATHER'S NAME (First, Middle, Last) <b>Littleton Potter</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nettie Turpin</b>				19a. INFORMANT'S NAME (Type/Print) <b>Ora Lee Potter</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>21 Roosevelt Ave. Aberdeen, Maryland 21001</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Berkley Cemetery</b>		20c. LOCATION — City or Town, State <b>7/26/91 Darlington, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Arnold W. Beard Funeral Service</b> <b>P.O. Box 188 Havre de Grace, Maryland 21078</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  <b>HEPATIC FAILURE</b> <b>RENAL FAILURE</b>  Approximate Interval Between Onset and Death <b>22 HRS</b> <b>22 HRS</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7/26/91</b>	
28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Whitman MD</b>		29c. LICENSE NUMBER <b>D 32609</b>	
29d. DATE SIGNED (Month, Day, Year) <b>7/19/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KAMRUDIN MITTHANI MD 703 Revolution St. Havre de Grace MD 21078</b>		31. DATE FILED (Month, Day, Year) <b>7/29/91</b>	
32. REGISTRAR'S SIGNATURE <i>[Signature]</i>				33. REGISTRAR'S TITLE <b>Registrar</b>		34. REGISTRAR'S OFFICE <b>Harford</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at steel



91 21662

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ISABELLE TOULSON</b>		2. DATE OF DEATH MONTH <b>July</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2250</b> M
4. SOCIAL SECURITY NUMBER <b>220-32-8909</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>1-30-11</b>	8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>
RESIDENCE OF DECEASED				
10a. STATE <b>MD</b>	10b. COUNTY <b>WICOMICO</b>	10c. CITY, TOWN OR LOCATION <b>SALISBURY</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>1003 RUSSELL AVENUE</b>		10f. ZIP CODE <b>21801</b>	10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 YEARS</b> College (14 or 5+) <b>4 YEARS</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>TEACHING</b>
17. FATHER'S NAME (First, Middle, Last) <b>JOHN M. TOULSON</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAUDE RINGOLD TOULSON</b>		
19a. INFORMANT'S NAME (Type/Print) <b>HAROLD PORTER</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1001 RUSSELL AVE. SALISBURY, MD 21801</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>PARSONS CEMETERY</b>		20c. LOCATION — City or Town, State <b>SALISBURY, MARYLAND</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John N. Holloway</i>		22. NAME AND ADDRESS OF FACILITY <b>HOLLOWAY FUNERAL HOME</b> <b>501 SNOW HILL RD SALISBURY, MD 21801</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction - primary site could not be determined</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arteriosclerosis Cardiovascular Disease</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>James H. Clifford MD</i>		
		29c. LICENSE NUMBER <b>201969</b>	29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAMES H. CLIFFORD MD SUITE 12 MEDICAL CENTER SALISBURY, MD 21801</b>				
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

2014-2015

10-5-11

91 21663

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Santo J. Perry				2. DATE OF DEATH MONTH DAY YEAR July 25 1991		3. TIME OF DEATH 6:00 A.M. M	
4. SOCIAL SECURITY NUMBER 208-10-3429		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) July 17 1914	
8. BIRTHPLACE (State or Foreign Country) Wishaw, PA				9a. FACILITY NAME (If not institution, give street and number) 10100 Coastal Highway Unit 810		9b. CITY, TOWN OR LOCATION OF DEATH Ocean City, Maryland	
9c. COUNTY OF DEATH Worcester				10a. STATE Pennsylvania		10b. COUNTY Jefferson	
10c. CITY, TOWN OR LOCATION Reynoldsville				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER Rt. 2 Box 311	
10f. ZIP CODE 15851				10g. CITIZEN OF WHAT COUNTRY? USA		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 College (1-4 or 5+) 10				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Owner/Operator		16b. KIND OF BUSINESS/INDUSTRY Sanitation Co.	
17. FATHER'S NAME (First, Middle, Last) John Perry				18. MOTHER'S NAME (First, Middle, Maiden Surname) Susie Toven			
19a. INFORMANT'S NAME (Type/Print) Dorothy T. Perry				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Rt. 2 Box 311, Reynoldsville, PA 15851			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) St. Mary's Cemetery		20c. LOCATION — City or Town, State 7-29-91 Winslow Township, PA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. Hutz</i>				22. NAME AND ADDRESS OF FACILITY Hastings Funeral Home, Selbyville, DE			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death Years
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) Vacation Residence			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide 7 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Peter S. Abbott M.D.</i>				29c. LICENSE NUMBER D 30619		29d. DATE SIGNED (Month, Day, Year) July 25, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Peter S. Abbott, M.D. 10445 Ocean City Blvd, Berlin Maryland 21811							
31. DATE FILED (Month, Day, Year) Jul 26 '91				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at sleep

at sleep

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91-21664

1. DECEDENT'S NAME (First, Middle, Last) <b>James Walter Proctor</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7-26-91</b>		3. TIME OF DEATH <b>1:35a.m.</b>			
4. SOCIAL SECURITY NUMBER <b>579-12-5300A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/21/1914</b>			
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not Institution, give street and number) <b>So. Maryland Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Clinton</b>			
9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Charles</b>			
10c. CITY, TOWN OR LOCATION <b>Pomfret</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Rt. 2 Box 112</b>			
10f. ZIP CODE <b>20675</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced			
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Harry Gulf Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George Washington Proctor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Regina Thompson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mary E. Proctor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 2 Box 112 Pomfret MD 20675</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Joseph Cath Ch. 7/31/91 Pomfret MD</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lloyd M. Ester</b>				22. NAME AND ADDRESS OF FACILITY <b>Adams Funeral Home, Aquasco Md 20608</b>					
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of liver</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): <b>pneumothorax</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>high bilirubin &gt; 3mg/l</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>D.M. MOASSEN MD</b>					
29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stanley M. Caldwell, Brandywine MD, D.M. MOASSEN</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 31 '91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

4011

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91 21665

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Gertrude Sarah Elizabeth</i>				2. DATE OF DEATH MONTH <i>July</i> DAY <i>17</i> YEAR <i>1991</i>				3. TIME OF DEATH <i>0019</i> M		
4. SOCIAL SECURITY NUMBER <i>219-03-4504</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>91</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>11-23-1899</i>		8. BIRTHPLACE (State or Foreign Country) <i>md.</i>		
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>		
RESIDENCE OF DECEDENT										
10a. STATE <i>md</i>		10b. COUNTY <i>Wicomico</i>		10c. CITY, TOWN OR LOCATION <i>Parsonburg</i>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10a. STREET AND NUMBER <i>207 Everglade Dr.</i>				10f. ZIP CODE <i>21801</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <i>BIK</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i>			16b. KIND OF BUSINESS/INDUSTRY <i>Domestic</i>			
17. FATHER'S NAME (First, Middle, Last) <i>William Gordy</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Rebecca Gordy</i>						
19a. INFORMANT'S NAME (Type/Print) <i>Iva Mary</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>207 Everglade Dr. Salisbury, md 21801</i>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)			DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Russell J. J. J.</i>				22. NAME AND ADDRESS OF FACILITY <i>Jackson Funeral Home P.O. Box 1574 Salisbury, Md 21801</i>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Multorgan failure</i> a. DUE TO (OR AS A CONSEQUENCE OF): <i>A.S.V.D. CHF</i> b. DUE TO (OR AS A CONSEQUENCE OF): <i>renal failure</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. SEQUENTIALLY LIST CONDITIONS, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>old stroke, decubitus ulcers</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <i>025036</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/17/91</i>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>H.R. Heda 614-D-Eastern Shore Dr. Salisbury md 21801</i>										
31. DATE FILED (Month, Day, Year) <i>JUL 23 91</i>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

20015 10

20015 10

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21666

1. DECEDENT'S NAME (First, Middle, Last) <b>ELIZABETH ANN QUADE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1991</b>		3. TIME OF DEATH <b>7:00 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>217-36-7435</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR. 24, 1909</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Mary's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Leonardtwn</b>		9c. COUNTY OF DEATH <b>St. Mary's</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ST. MARY'S CO.</b>		10c. CITY, TOWN OR LOCATION <b>CLEMENTS</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>GENERAL DELIVERY</b>				10f. ZIP CODE <b>20624</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH. GRADE</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		15b. KIND OF BUSINESS/INDUSTRY <b>HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM FRANCIS PILKERTON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESTHER ODIE GATTON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY ELIZABETH KNOTT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>GENERAL DELIVERY, CLEMENTS, MARYLAND 20624</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>QUEEN OF PEACE CEMETERY 8/05/91</b>		20c. LOCATION — City or Town, State <b>HELEN, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael K. Anderson</i>				22. NAME AND ADDRESS OF FACILITY <b>MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MD. 20650</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Brainstem infarction</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Arteriosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Disease</b> <b>My hypertension</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John F. Fenwick</i>				29c. LICENSE NUMBER <b>D01380</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.2.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN F. FENWICK M.D. LEONARDTOWN</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 05 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

at Steep

REG. NO.

DHMH-18 Rev 1/89

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE MEDICAL EXAMINER: If there is any **traumatic event** or **other** **traumatic event** the medical examiner must be notified at once.

at Siegel

91 21668

REG. NO.

OHMM-18 Rev 1/89

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

**DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020**

**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21669

1. DECEASED'S NAME (First, Middle, Last) <b>Jerry RHODES</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1106 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>200-28-5422</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>5-24-1935</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Univ. MD Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balt MD</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Hampstead</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>4005 Shiloh Avenue</b>		10f. ZIP CODE <b>21074</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Elevator Constructor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Dover Elevator</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George R. Rhodes</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sara H. Mallory</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Evelyn L. Booth</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3318 S. E., Okeechobee, Fla. 33474</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Grove Cemetery 8/10/91</b>		20c. LOCATION — City or Town, State <b>Fayette, Pa.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Steven W. Elise</b>		22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home 934 S. Main Street, Hampstead, Md. 21074</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Subarachnoid Hemorrhage</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Cerebral herniation syndrome</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>Home</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Arthur J. Dibrati Jr</b>		29c. LICENSE NUMBER <b>7/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Arthur J. Dibrati Jr</b>		31. DATE FILED (Month, Day, Year) <b>JUL 30 '91</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HOWARD F. RADCLIFFE</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 20, 1991</b>		3. TIME OF DEATH <b>8:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-07-0462</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-13-08</b>	
8. BIRTHPLACE (State or Foreign Country) <b>WV Ridgeley</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>803 Trost Avenue</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>V.P. of Distribution</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Tire Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Jonathan Radcliffe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie F. (Bischoff)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James H. Radcliffe</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7165 Laurinda Lane, Orange, Calif. 92669</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 7/24 Cumberland</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William Kight</i>				22. NAME AND ADDRESS OF FACILITY <b>Kight Funeral Home 309 Decatur St., Cumberland, Md. 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Melanoma, Malignant</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <b>Metastatic</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>2 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) <input checked="" type="checkbox"/> HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <input type="checkbox"/> OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CARRYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. W. Fiscus</i>				29c. LICENSE NUMBER <b>D 12779</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. W. Fiscus, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 13146.

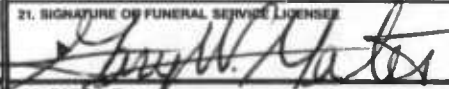

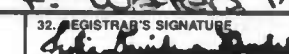
THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE HONORABLE CHIEF OF THE BUREAU OF HEALTH, DEPARTMENT OF HEALTH, MASSACHUSETTS.

TO THE FUNERAL DIRECTOR, After this certificate has been signed by an attending physician and completely filed in of and returned enclosed, page a certificate to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

FOR 1 - STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT FRANKLIN REID</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 20, 1991</b>		3. TIME OF DEATH <b>6:30 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215 12 6621</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>70</b> YRS.	7. DATE OF BIRTH MONTH DAY YEAR <b>MAY 31, 1921</b>		8. BIRTHPLACE (State or Foreign Country) <b>VIENNA, MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>8807 W. BISCAYNE DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>OCEAN CITY</b>		9c. COUNTY OF DEATH <b>WORCHESTER</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>WORCHESTER</b>		10c. CITY, TOWN OR LOCATION <b>OCEAN CITY, MARYLAND</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8807 W. BISCAYNE DRIVE</b>				10f. ZIP CODE <b>21842</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12YRS</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SECURITY GUARD</b>		15b. KIND OF BUSINESS/INDUSTRY <b>CON DIESEL, INC. SALISBURY, MARYLAND</b>			
17. FATHER'S NAME (First, Middle, Last) <b>HANNIBAL H. (NK) REID</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESNA DAY REID</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LEONARD B. REID (NEPHEW)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6 WESTERLY DRIVE: DELMAR, DELAWARE 19940</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ODD FELLOWS CEMETERY</b>		20c. LOCATION — City or Town, State <b>SEAFORD, DEL. 19973</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0793</b>				22. NAME AND ADDRESS OF FACILITY <b>WATSON-YATES FUNERAL HOME, INC. SEAFORD, DELAWARE 19973</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): <b>PROSTATE CANCER</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER <b>27993</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-22-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stephen F. Waters M.D. 1001 Philadelphia Ave. Ocean City, MD 21842</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 22 91</b>		32. REGISTRAR'S SIGNATURE 					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAYES R. SKILES</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:30 AM</b>	
4. SOCIAL SECURITY NUMBER <b>185-03-1121</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>91</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN 17 1900</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HARFORD Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HARFORD, Md</b>		9c. COUNTY OF DEATH <b>HARFORD</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CECIL</b>		10c. CITY, TOWN OR LOCATION <b>RISING SUN</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>34 LEEDLE CIRCLE</b>				10f. ZIP CODE <b>21911</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>UNKNOWN</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISPATCHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OIL COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN W. SKILES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY JANE KANE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ANNA M. SKILES</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34 LEEDLE CIRCLE RISING SUN, MD 21911</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>OXFORD CEMETERY 7-25-91</b>		20c. LOCATION — City or Town, State <b>OXFORD, PA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard L. Groffie</i>				22. NAME AND ADDRESS OF FACILITY <b>R.T. FOARD FUNERAL HOME RISING SUN, MARYLAND</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEPATO RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):						Approximate interval Between Onset and Death <b>5 DAYS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ca Prostate with Metastases</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 8 <input type="checkbox"/> Homicide		28. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>William MD</i>		29c. LICENSE NUMBER <b>D32609</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KAMRUDIN MITHANI MD 703 Revolution St Harre De Grace MD 21078</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 6 may be retained by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Walter James Stumpf				2. DATE OF DEATH MONTH 7 DAY 23 YEAR 91		3. TIME OF DEATH 1705 M	
4. SOCIAL SECURITY NUMBER 215-68-0208		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 38 YRS.	7. DATE OF BIRTH (Month, Day, Year) 7-15-53		8. BIRTHPLACE (State or Foreign Country) Delaware	
9a. FACILITY NAME (If not institution, give street and number) Union Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Elkton		9c. COUNTY OF DEATH Cecil	
10a. STATE Maryland				10b. COUNTY Cecil		10c. CITY, TOWN OR LOCATION North East	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 41 Weaver Road				10f. ZIP CODE 21901		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: white	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) n/a		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Correctional Officer		16b. KIND OF BUSINESS/INDUSTRY Law Enforcement			
17. FATHER'S NAME (First, Middle, Last) Allen Frederick Stumpf				18. MOTHER'S NAME (First, Middle, Maiden Surname) Edna May Broadbent			
19a. INFORMANT'S NAME (Type/Print) Susan L. Stumpf				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 41 Weaver Road North East, Maryland 21901			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) North East United Methodist		20c. LOCATION — City or Town, State North East, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert M. Crouch</i>				22. NAME AND ADDRESS OF FACILITY Crouch Funeral Home 127 S. Main St. North East, Maryland 21901			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Cardiac death DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> OOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas E. Finucan, Jr.</i>				29c. LICENSE NUMBER D32395		29d. DATE SIGNED (Month, Day, Year) 7-25-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Thomas E. Finucan, Jr., M.D. 3 Mauldin Ave. North East, MD 21901							
31. DATE FILED (Month, Day, Year) JUL 26 '91		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51673

1951-1952

1951-1952

1951-1952

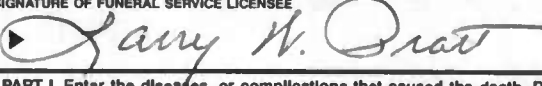

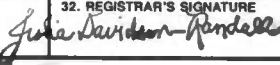
1951-1952



91 21674

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LAWRENCE M. SPRIGGS, SR</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>14</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1225 P</b> M	
4. SOCIAL SECURITY NUMBER <b>216-30-4586</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>12/14/34</b>		8. BIRTHPLACE (State or Foreign Country) <b>Collington, Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Doctor's Hospital of P.G.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Lanham</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>MD</b>		10b. COUNTY <b>PG</b>		10c. CITY, TOWN OR LOCATION <b>BOCUE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4503 WOOD GATE WAY</b>		10f. ZIP CODE <b>20715</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>1 yr.</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lab Technician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Richard M. Spriggs</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen C. Brown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Barbara Dawson</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1521 Kings Hill St., Mitchellville, Md. 20715</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Mem. Park 7/20/91</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>H.S. Washington &amp; Sons, Inc. 4925 Burroughs Ave., NE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIAC ARRHYTHMIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ATHEROSCLEROTIC HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. HYPERTENSION</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death <b>min</b> <b>YRS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>MD 19815</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/14/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Greater Laurel Bestville Hospital, Laurel, MD 20707</b>					
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21675

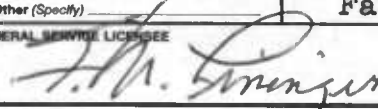
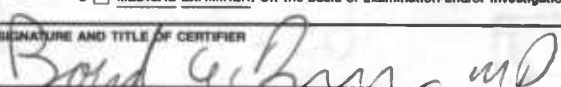
1. DECEASED'S NAME (First, Middle, Last) <b>FLORINE SCOTT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>07 21 91</b>		3. TIME OF DEATH <b>9:10 PM</b>	
4. SOCIAL SECURITY NUMBER <b>240 58 9471</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>51</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 27, 1939</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, DC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGE'S HOSPITAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>		10c. CITY, TOWN OR LOCATION <b>Palmer Park</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7533 Greenleaf Rd.</b>				10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Johnson Wood</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Oneil Haney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>David Scott</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7533 Greenleaf Rd. Palmer Park, MD 20785</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park</b>		20c. LOCATION — City or Town, State <b>Landover, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jimmy G. Neal Sr.</i>				22. NAME AND ADDRESS OF FACILITY <b>J.B. Jenkins Funeral Home 7474 Landover Rd. Landover, MD 20785</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Coronary Artery Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>DIABETES MELLITUS</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ASTHMA</b> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>MINUTES</b> <b>YEARS</b> <b>YEARS</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>OBESITY</b> <b>ALCOHOL BINGING.</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. George Bone</i>					
		29c. LICENSE NUMBER <b>D31069</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/23/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. George Bone 9602 E Martin L.K Jr. Hwy, Lanham, MD 20706</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 '91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

21 5:19:32

91 21676

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM E SWISHER</b>		2. DATE OF DEATH MONTH <b>7</b> DAY <b>30</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:20 P M</b>
4. SOCIAL SECURITY NUMBER <b>186-24-8562</b>	5. SEX <b>1 M 2 F</b>	8. AGE (In yrs. last birthday) <b>59</b> YRS.	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>	IF UNDER 24 HRS. HOURS <b>0</b> MIN. <b>0</b>
7. DATE OF BIRTH (Month, Day, Year) <b>9/21/31</b>		8. BIRTHPLACE (State or Foreign Country) <b>Cove Gap, Pa.</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>FREDERICK MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>FREDERICK</b>		9c. COUNTY OF DEATH <b>FREDERICK</b>
10a. STATE <b>Md.</b>		10b. COUNTY <b>Frederick</b>		10c. CITY, TOWN OR LOCATION <b>Monroevia</b>
10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>4513 Green Valley Rd.</b>		
10f. ZIP CODE <b>21770</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>Korean Conflict</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 Elementary/Secondary (0-12) 1 College (1-4 or 5+)</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steam-fitter</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Const.</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Brady V. Swisher</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Mellott</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Aletha N. Swisher</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, ZIP Code) <b>4513 Green Valley Rd., Monroevia, Md. 21770</b>		
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Fairview Cem. 8/2</b>		20c. LOCATION — City or Town, State <b>Mercersburg, Pa.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Lininger-Fries Funeral Home 47 N. Park Ave., Mercersburg, Pa. 17236</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INTRACEREBRAL HEMORRHAGE</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death <b>24 HRS</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   				24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>		
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <b>1 YES 2 NO</b>
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				
29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER <b>D37501</b>	29d. DATE SIGNED (Month, Day, Year) <b>7/30/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BOYD, A. DWYER MD 915 JOLLY HASE AVE SUITE 305 FREDERICK, MD 21702</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 08 1991</b>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) GORDON ROBERT SQUIRES				2. DATE OF DEATH MONTH DAY YEAR JULY 26 1991		3. TIME OF DEATH 9:52P M	
4. SOCIAL SECURITY NUMBER 008-10-2179		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB 23 1923	
8. BIRTHPLACE (State or Foreign Country) VERMONT							
9a. FACILITY NAME (If not institution, give street and number) NATIONAL NAVAL MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH BETHESDA		9c. COUNTY OF DEATH MONTGOMERY	
10a. STATE VIRGINIA				10b. COUNTY ORANGE		10c. CITY, TOWN OR LOCATION LOCUST GROVE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER BOX 129 LAKE OF THE WOODS				10f. ZIP CODE 22508		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES 1944-1961		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 2				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) USMC		16b. KIND OF BUSINESS/INDUSTRY DEFENSE	
17. FATHER'S NAME (First, Middle, Last) JESSIE SQUIRES				18. MOTHER'S NAME (First, Middle, Maiden Surname) HAZEL KINNEY			
19a. INFORMANT'S NAME (Type/Print) GWENDOLYN D. SQUIRES				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) BOX 129 LOW, LOCUST GROVE, VA 22508			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Quantico National 7/31		20c. LOCATION — City or Town, State Quantico, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John M Tierney #083				22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home, Locust Grove, Va/			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → e. NON SMALL CELL CARCINOMA OF THE LUNG DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER C. R. Halliburton				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 7-27-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) C. R. HALLIBURTON, LT. MC, USNR				NATIONAL NAVAL MEDICAL CENTER BETHESDA, MD 20889-5000			
31. DATE FILED (Month, Day, Year) AUG 08 1991				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Wilbur Oscar Sherfey</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7 27 1991</b>		3. TIME OF DEATH <b>9 43 pm</b>	
4. SOCIAL SECURITY NUMBER <b>212-16-4818</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-11-1909</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Westminster Nursing &amp; Convalescent Ctr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Westminster</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Carroll</b>		10c. CITY, TOWN OR LOCATION <b>Westminster</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1234 Washington Rd.</b>			
10f. ZIP CODE <b>21157</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Auto Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Owner-Sherfey's Service Station</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John William Sherfey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Allie Hahn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dean E. Sherfey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Ocean City, Md.</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baust Cemetery</b>		20c. LOCATION — City or Town, State <b>Tyrone, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Nancy K. Fletcher</i>				22. NAME AND ADDRESS OF FACILITY <b>Fletcher Funeral Home 254 East Main St. Westminster, Md. 21157</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardiac Myopathy</b> DUE TO (OR AS A CONSEQUENCE OF) <b>b. Myocardial Infarct</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>c. ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>						Approximate Interval Between Onset and Death <b>2 weeks</b> <b>3 weeks</b> <b>75 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal Disease</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William R. O'Rourke</i>				29c. LICENSE NUMBER <b>DO 9389</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO

91 21679

1. DECEASED'S NAME (First, Middle, Last) <b>CHARLOTTE HESS SHORB</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>26</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>0946</b>			
4. SOCIAL SECURITY NUMBER <b>220-03-2901</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JUNE 18, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>CARROLL COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>WESTMINSTER</b>				9c. COUNTY OF DEATH <b>CARROLL</b>			
RESIDENCE OF DECEASED											
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>CARROLL</b>		10c. CITY, TOWN OR LOCATION <b>TANEYTOWN</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4038 BAPTIST ROAD</b>				10f. ZIP CODE <b>21787</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>CAUCASIAN</b>			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 YEARS</b> College (1-4 or 5+) <b>FOOD SERVICE MANAGER</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ELEMENTARY EDUCATION</b>			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <b>RALPH E. HESS</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDNA HARNER</b>						
19a. INFORMANT'S NAME (Type/Print) <b>KENNETH C. SHORB</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4038 BAPTIST ROAD TANEYTOWN, MD 21787</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SMITHSBURG CREMATORY 7/26</b>			DATE <b>SMITHSBURG, MD</b>		20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>P. Kevin Judy</b>				22. NAME AND ADDRESS OF FACILITY <b>136 EAST BALTIMORE ST SKILES FUNERAL HOME TANEYTOWN, MD</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory failure</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Bilateral pleural effusion</b> <b>carcinoma of breast</b>								Approximate interval Between Onset and Death <b>Instant</b>  <b>Smoker</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Conradish Nagan</b>					29c. LICENSE NUMBER <b>D18200</b>			29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHITRACHEDU NAGANNA 700 A pole rd westminster MD 21157</b>											
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>									

at 5121a

91 21680

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY SEIFERT</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>23</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:54</b> M	
4. SOCIAL SECURITY NUMBER <b>147-18-8776</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>65</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/1/26</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>	
9c. COUNTY OF DEATH <b>WICOMICO</b>				10a. STATE <b>De.</b>		10b. COUNTY <b>Sussex</b>	
10c. CITY, TOWN OR LOCATION <b>Lewes</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>320 West Bay Park</b>	
10f. ZIP CODE <b>19958</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Lab Technician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DuPont Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Anderson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bary Benedict Anderson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James J. Seifert</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>320 W. Bay Park Lewes, De. 19958</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Gardens 7-25</b>		20c. LOCATION — City or Town, State <b>Hebron, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William M. Hoth</i>				22. NAME AND ADDRESS OF FACILITY <b>Short Windsor Disharoon Funeral Home, Inc. P.O. Box 678 Laurel, De. 19956</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiogenic Shock</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Acute Myocardial Infarction</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>ASCVD</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amel M. Gump</i>				29c. LICENSE NUMBER <b>W3311</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD WOOD QUINCY + LOCUST SALISBURY MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

William M. Hall

91 21681

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM LEWIS STEPHEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>JULY 22, 1991</b>		3. TIME OF DEATH <b>9:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214 05 9858</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 7, 1904</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>		9c. COUNTY OF DEATH <b>ALLEGANY</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Lonaconing</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>32 St. Mary's Terrace</b>			
10f. ZIP CODE <b>21539</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>0</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Rubber Tire Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Tire Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Lewis H. Stephen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebecca Miller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Carolyn McKenzie</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Buck Hill, Lonaconing, Md. 21539</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, funeral home, or other place) <b>Laurel Hill Cem. 7-25-91</b>		20c. LOCATION — City or Town, State <b>Moscow Mills, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. McKenzie</i>				22. NAME AND ADDRESS OF FACILITY <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary Failure</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>COPD</b>  DUE TO (OR AS A CONSEQUENCE OF): a. <b>COPD</b> b. c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ASVD</b> <b>Diabetes mellitus</b>						Approximate Interval Between Onset and Death <b>Weeks</b> <b>years</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Wayne Spiggle</i>				29c. LICENSE NUMBER <b>D11443</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/22/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. WAYNE SPIGGLE, M.D., BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 7, 8, and 9 will be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COLLON



91 21682

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN Edward SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 23 1991</b>		3. TIME OF DEATH <b>11:00A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-4633</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-19-1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1120 Shades Lane</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner Smith Garden Center</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Landscaping &amp; Garden</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lawrence Edward Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emilie Lauterbach</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Anna Walburn Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1120 Shades Lane, Cumberland, Md. 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 7/25/91</b>		20c. LOCATION — City or Town, State <b>Cumberland, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Ernest A. Riley, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Leasure-Stein, Inc. 230 Baltimore Av. Cumberland, Md. 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Advanced Parkinson's Disease</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): <b>Assoc. Brain</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. W. Fiscus</b>				29c. LICENSE NUMBER <b>D 12779</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. W. Fiscus, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 11:00

91 21683

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHLEEN STEVENS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 24, 1991</b>		3. TIME OF DEATH <b>4:40 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>214-07-6533</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>74</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>3-3-17</b>		8. BIRTHPLACE (State or Foreign Country) <b>allegany</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Cumberland</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>829 East First Street</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Factory Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Celenece</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Harry Retzer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara Ella Sturtz</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Janet M. Miller</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>829 East First Street Cumb. MD. 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St Marys Cemetery 7-27-91</b>		20c. LOCATION — City or Town, State <b>Cumberland, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home 108 Virginia ave. Cumb. Md 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Peritoneal Carcinomatosis</b>						Approximate interval between Onset and Death <b>days.</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Undetermined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Sunil Gupta</b>				29c. LICENSE NUMBER <b>033280</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Sunil Gupta-Memorial Hospital Medical Building-Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, and 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARL RICHARD SMITH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>07 - 26 - 1991</b>		3. TIME OF DEATH <b>4:50 P.M. M</b>	
4. SOCIAL SECURITY NUMBER <b>213200150</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-17-23</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>ALLEGANY COUNTY</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>Green Ridge Mountain</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Star Route</b>				10f. ZIP CODE <b>21530</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steelworker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Steel Company</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Thaddeous S. Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bessie (Nolan) Smith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helena E. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Star Route, Flintstone, Maryland 21530</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Rocky Gap Veteran Cem. 7/30</b>		20c. DATE <b>7/30</b>		20d. LOCATION — City or Town, State <b>Flintstone</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William S. Kight</i>				22. NAME AND ADDRESS OF FACILITY <b>Kight Funeral Home 309 Decatur Street. Cumberland, Md.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac failure with arrhythmias</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; align-items: center;"> <div style="font-size: 3em; margin-right: 10px;">{</div> <div> <b>ASHD - recorded upon 7</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>COPD - further</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Diabetes mellitus</b> </div> </div>						Approximate Interval Between Onset and Death <b>21502</b> <i>some months</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Mehanne M.D.</i>					
		29c. LICENSE NUMBER <b>D-17526</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-29-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>DR. JOHN MEHANNA, M.D., 909-B SETON DRIVE, CUMBERLAND, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Richardson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, &amp; 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21685

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS C. SHARPS</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>218-10-3461</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9 20 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>ANNAPOLIS</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>1810 ROBERT SMALL ROAD</b>				10f. ZIP CODE <b>21401</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. NAVAL ACADEMY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE SHARPS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOTTIE PARKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELIZABETH HSARPS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1810 ROBERT SMALL RD. ANNAPOLIS, MD. 21401</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HILL CREST CEMETERY</b>		20c. LOCATION — City or Town, State <b>ANNAPOLIS, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <b>821 WEST ST. ANNAPOLIS, MD: 21401</b> <b>REESE &amp; SONS MORTUARY, P.A.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Arteriosclerosis</b> c. <b>Hypertension</b> d. <b>Diabetes</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert Lee MA</i>				29c. LICENSE NUMBER <b>0 01846</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/21/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Gina Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

THE UNIVERSITY OF CHICAGO

PHYSICS DEPARTMENT



91 21686

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Clifford Lee Schneider Sr.</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1500</b> M	
4. SOCIAL SECURITY NUMBER <b>578-18-4030</b>		5. SEX <b>MM</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-20-04</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Richmond, VA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Anne Arundel Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Edgewater</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1609 Bentley Road</b>	
10f. ZIP CODE <b>21037</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>13</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Printer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Printing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John George Schneider</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lottie Garland</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Frances S. Tomaselli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5230 Old Castle Lane, Springfield, VA 22151</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakemont Cemetery</b>		20c. LOCATION — City or Town, State <b>Davidsonville, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Thomas Hardesty</b>				22. NAME AND ADDRESS OF FACILITY <b>Hardesty Funeral Home, P.A. 12 Ridgely Avenue, Annapolis, MD</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>12 chronic heart disease</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death <b>28 yrs.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>General Oliver</b>				29c. LICENSE NUMBER <b>001265</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>8 EVERGREEN RD. SEVERNA PARK, MD 21146</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3, 4, and 5 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Sarah G. Stallings</i>				2. DATE OF DEATH MONTH <i>7</i> DAY <i>27</i> YEAR <i>91</i>		3. TIME OF DEATH <i>9:00 A.</i> M.	
4. SOCIAL SECURITY NUMBER <i>212 74 1906</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH MONTH <i>9</i> DAY <i>12</i> YEAR <i>1902</i>	
8. BIRTHPLACE (State or Foreign) <i>MARYLAND</i>							
9a. FACILITY NAME (If not institution, give street and number) <i>ANNAPOLIS NURSING HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>ANNAPOLIS</i>		9c. COUNTY OF DEATH <i>ANNE ARUNDEL</i>	
10a. STATE <i>MD</i>		10b. COUNTY <i>ANNE ARUNDEL</i>		10c. CITY, TOWN OR LOCATION <i>ANNAPOLIS</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>305 MELVIN AVE.</i>				10f. ZIP CODE <i>21401</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOUSEWIFE</i>		16b. KIND OF BUSINESS/INDUSTRY <i>HOMEMAKER</i>	
17. FATHER'S NAME (First, Middle, Last) <i>GEORGE ROGERS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>REBECCA WILNER</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MARGARET FEESER</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>307 MELVIN AVE ANNAPOLIS, MD 21401</i>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>7/27/91 METROPOLITAN CREMATORY ALEX. VA.</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lytle</i>				22. NAME AND ADDRESS OF FACILITY <i>TAYLOR FUNERAL CHAPEL ANNAPOLIS, MARYLAND</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiac failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Arteriosclerotic cardiovascular disease</i> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <i>12 hrs.</i>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard N. Peeler MD</i>				29c. LICENSE NUMBER <i>D12452</i>		29d. DATE SIGNED (Month, Day, Year) <i>7/27/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>RICHARD N. PEELER, ANNAPOLIS, MD</i>							
31. DATE FILED (Month, Day, Year) <i>JUL 30 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PATRICK BASSETT STEVENS</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>02:00 AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-98-5350</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-26-1957</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Minnesota</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>	
9c. COUNTY OF DEATH <b>ANNE ARUNDEL CO.</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Crownsville</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>538 Wilson Road</b>				10f. ZIP CODE <b>21032</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Landscaper</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Landscaping</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Dale Stevens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Patricia Stevens Crowley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dale B. Stevens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5910 Dart Drive, Lithonia, GA 30058</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metropolitan Crematory 7/31</b>		20c. LOCATION — City or Town, State <b>Alexandria, VA</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donald S. Lyter</i>				22. NAME AND ADDRESS OF FACILITY <b>Taylor Funeral Chapel 21401 147 Gloucester St., Annapolis, MD</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. HANGING</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7-28-91</b>		28b. TIME OF INJURY <b>01:30</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT HUNG SELF IN JAIL</b>				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>JAIL CELL</b>			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>A.A.CO. POLICE STATION</b>				28g. DIST. <b>SOUTHEAST</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert M. McNeill</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-29-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margaret A. Kowalski 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

[Faint, mostly illegible text covering the majority of the page, possibly a form or document with multiple sections.]

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ERNEST HARVEY</b>		2. DATE OF DEATH MONTH DAY YEAR <b>July 19, 1991</b>		3. TIME OF DEATH <b>1600</b>	
4. SOCIAL SECURITY NUMBER <b>214-10-6982</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>2-10-1906</b>		8. BIRTHPLACE (State or Foreign Country) <b>De.</b>		9. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Box 371 Salisbury Mobile Home Park</b>		10f. ZIP CODE <b>21801</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Maintenance Man</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cemetery</b>		17. FATHER'S NAME (First, Middle, Last) <b>William H. Snyder</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Ann (Maiden unknown) Snyder</b>		19a. INFORMANT'S NAME (Type/Print) <b>Rosa Cannon Pusey Snyder</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 371 Salisbury Mobile Home Pk. Salisbury, Md. 21801</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parsons Cemetery</b>		20c. LOCATION — City or Town, State <b>7-22 Salisbury, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>William M. Short</b>		22. NAME AND ADDRESS OF FACILITY <b>Short Funeral Home, Inc. P.O. Box 204 Delmar, De. 19940</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Congestive Heart Failure</b> <b>Diffuse Atherosclerosis</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul R. Fleury MD</b>		29c. LICENSE NUMBER <b>024872</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/20/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL R. FLEURY MD 560 RIVERSIDE DR SALISBURY MD</b>		31. DATE FILED (Month, Day, Year) <b>JUL 22 91</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

at 51882

x

*Handwritten signature*

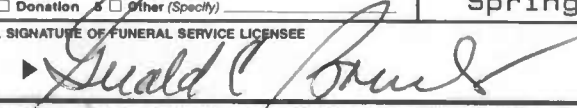


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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Oscar L. &amp; Shrieves</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>23</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>5:30 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>216-01-8644A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-22-08</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VA.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury, Md.</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>MD.</b>		10b. COUNTY <b>Wicomico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>509 c Chelsea Court</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mechanic</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto Agency</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Oscar James Shrieves</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara East</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Audrey Webb Shrieves</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>509C Chelsea Court Salisbury Md. 21801</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Garden</b>		20c. LOCATION — City or Town, State <b>Hebron Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>705 E. Main Street Salisbury Maryland 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Edema</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Possible Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Advanced Chronic obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate interval Between Onset and Death <b>7 Hrs.</b>   <b>Years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Dr. Ina Hwang M.D.</b>				29c. LICENSE NUMBER <b>D16003</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/23/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Deer's Head Center Salisbury, Md. 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 91</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely used in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <u>Michael C. Trimboli</u>				2. DATE OF DEATH MONTH <u>7</u> DAY <u>21</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>4:50 a.m.</u>	
4. SOCIAL SECURITY NUMBER <u>233-22-0887</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>80</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>August 3, 1910</u>	
8. BIRTHPLACE (State or Foreign Country) <u>West Virginia</u>				9. FACILITY NAME (If not institution, give street and number) <u>Southern Maryland Hospital</u>			
10. CITY, TOWN OR LOCATION OF DEATH <u>Clinton</u>				11. COUNTY OF DEATH <u>P.G.</u>			
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Prince Georges</u>		10c. CITY, TOWN OR LOCATION <u>Morningside</u>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <u>4418 Morgan Rd.</u>				10f. ZIP CODE <u>20746</u>		10g. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>white</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>11</u> College (1-4 or 5+) <u>College</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Cement Mason</u>		16b. KIND OF BUSINESS/INDUSTRY <u>Construction</u>			
17. FATHER'S NAME (First, Middle, Last) <u>Joseph Trimboli</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Mary (Unknown)</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Phyllis E. Trimboli</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>4418 Morgan Rd., Morningside, MD. 20746</u>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <u>Resurrection Cemetery</u>		20c. DATE <u>6/24/91</u>		20d. LOCATION — City or Town, State <u>Clinton, MD.</u>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Dryan E. Gebel</u>				22. NAME AND ADDRESS OF FACILITY <u>4308 Suitland Rd. Robert E. Wilhelm, Inc. Suitland, MD. 20746</u>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Cardiopul. arrest</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>massive stroke</u> c. <u>(V) Hemiparesis</u> d. <u>Aphasia</u>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Quel c. A. 50-60</u> <u>coron</u> <u>CHF</u> <u>Aspirin - P. n. n.</u> <u>coron</u> <u>pul. st. ectasis</u>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <u>U. A. H. allardy</u>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>7/21/91</u>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>ABUL HASAN ANSARI MD</u> <u>8926 Woodland Rd #101</u> <u>Clinton Md. 20735</u>							
31. DATE FILED (Month, Day, Year) <u>JUL 24 '91</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



UNKNOWN 91-113

FEH

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MAURICE ALBERT TAYLOR JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>06 29 1991</b>		3. TIME OF DEATH <b>19:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>Unknown</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>31</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>08-29-1959</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CAPITOL HIEGHTS BLVD. AND MARLBORO PKWY.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CAPITOL HIEGHTS</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD.</b>		10b. COUNTY <b>P.G.</b>		10c. CITY, TOWN OR LOCATION <b>Hillcrest Heights</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3352 Curtis Dr. Hillcrest Hgts.</b>				10f. ZIP CODE <b>20748</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Maurice A. Taylor</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Maude Brown Moore</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Maude Moore</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6401 Hilmar Dr. Forestville, Md. 20748</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony</b>		20c. LOCATION — City or Town, State <b>Landover</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Janice Edwards</b>				22. NAME AND ADDRESS OF FACILITY <b>Hodges &amp; Edwards</b> <b>3720 Old Silver Hill Rd. md.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Gunshot Wounds of Head</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input checked="" type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>UNKNOWN</b>		28b. TIME OF INJURY <b>UNK M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT MULTIPLE TIMES</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>WOODS</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>CAPITOL HIEGHTS BLVD. &amp; MARLBORO PKWY.</b>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>FRANCIS J. PENNETT</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>06-30-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS J. PENNETT III PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 23 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21693

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) RAYMOND David TWOMEY				2. DATE OF DEATH MONTH 7 DAY 19 YEAR 91		3. TIME OF DEATH 2.55 AM M			
4. SOCIAL SECURITY NUMBER 577 66 6661		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 43 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 21 1948		8. BIRTHPLACE (State or Foreign Country) Portland Maine	
9a. FACILITY NAME (If not institution, give street and number) PRINCE GEORGES HOSP CENTER				9b. CITY, TOWN OR LOCATION OF DEATH CHEVERLY			9c. COUNTY OF DEATH PRINCE GEORGES		
10a. STATE Maryland		10b. COUNTY Prince George's		10c. CITY, TOWN OR LOCATION Bowie			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 2701 Felter Lane				10f. ZIP CODE 20715		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Caucasian		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) -12-		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Land Surveyor		16b. KIND OF BUSINESS/INDUSTRY Construction					
17. FATHER'S NAME (First, Middle, Last) Raymond E. Twomey				18. MOTHER'S NAME (First, Middle, Maiden Surname) Arlene McKenney					
19a. INFORMANT'S NAME (Type/Print) Raymond E. Twomey				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2701 Felter Lane Bowie, Maryland 20715					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Metropolitan Crematory			20c. LOCATION — City or Town, State Alexandria Virginia				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Robert E. Evans				22. NAME AND ADDRESS OF FACILITY Beall-Evans Funeral Home, P.A. 16000 Annapolis Road Bowie, Maryland 20715					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → SEPSIS Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. INTRAVENOUS DRUG ABUSE c. DUE TO (OR AS A CONSEQUENCE OF): d. CACHEXIA, DEHYDRATION e. DUE TO (OR AS A CONSEQUENCE OF): f. POSSIBLE AIDS RESULTS OF HIV NOT AVAILABLE Approximate Interval Between Onset and Death									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER A. G. K. M. I. C. E. V. FOR DR. TELAWI				29c. LICENSE NUMBER 34274		29d. DATE SIGNED (Month, Day, Year) 7/20/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3001 HOSP DR CHEVERLY MD 20785									
31. DATE FILED (Month, Day, Year) 7/20/91				32. REGISTRAR'S SIGNATURE John Davidson-Randall					


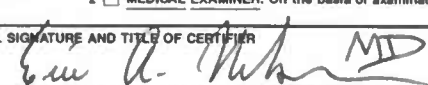
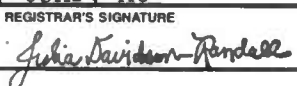
at 51933



91 21694

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) EDWARD SAMUEL TAYLOR				2. DATE OF DEATH MONTH: JULY DAY: 19 YEAR: 91		3. TIME OF DEATH 11:25 A M	
4. SOCIAL SECURITY NUMBER 224-22-1546		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 66 YRS.	7. DATE OF BIRTH (Month, Day, Year) 12-28-24		8. BIRTHPLACE (State or Foreign Country) VIRGINIA	
9a. FACILITY NAME (If not institution, give street and number) MALCOLM GROW HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH CLINTON		9c. COUNTY OF DEATH PRINCE GEORGES	
10a. STATE NA		10b. COUNTY NA		10c. CITY, TOWN OR LOCATION WASHINGTON, D.C.		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2211 U Place, S.E.				10f. ZIP CODE 20020		10g. CITIZEN OF WHAT COUNTRY? UNITED STATES	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES RETIRED U.S. NAVY		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MILITARY		16b. KIND OF BUSINESS/INDUSTRY U.S. NAVY			
17. FATHER'S NAME (First, Middle, Last) GEORGE W. TAYLOR				18. MOTHER'S NAME (First, Middle, Maiden Surname) MATTIE DAVIS			
19a. INFORMANT'S NAME (Type/Print) EDWARD T. TAYLOR (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2412 Corning Avenue #3, Ft. Wash., Maryland 20744			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) 7725791		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) ARLINGTON NATIONAL CEMETERY		20c. LOCATION — City or Town, State ARLINGTON, VA.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		M859		22. NAME AND ADDRESS OF FACILITY ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, SE DC 20020			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. LIVER FAILURE DUE TO HEPATOCELLULAR CARCINOMA DUE TO (OR AS A CONSEQUENCE OF): b. RENAL FAILURE DUE TO (OR AS A CONSEQUENCE OF): c. METABOLIC ACIDOSIS DUE TO (OR AS A CONSEQUENCE OF): d. HYPERKALEMIA Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death 1 WK
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC HEPATITIS B, PANCREATITIS							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  MD				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERIC A NELSON, CAPT, USAF, MC				MALCOLM GROW USAF MEDICAL CENTER ANDREWS AFB, MD 20331-5300			
31. DATE FILED (Month, Day, Year) JUL 22 '91		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51034

91 21695

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Claudia Viar Trust</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>26</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10<sup>16</sup> AM</b>	
4. SOCIAL SECURITY NUMBER <b>213-485186</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-19-11</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>	
9c. COUNTY OF DEATH <b>Harford</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Harford</b>	
10c. CITY, TOWN OR LOCATION <b>Fallston</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>910 Waters Avenue</b>	
10f. ZIP CODE <b>21047</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Claude Henry Viar</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Onie Sutphin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>William H. Trust</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2100 Durham Road, Fallston, Md. 21047</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bel Air Memorial Gardens 7-29-91</b>		20c. LOCATION — City or Town, State <b>Bel Air, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Howard K. McComas III</b>				22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Possible Pulmonary Embolus</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Dilated Cardiomyopathy</b> <b>Osteoporosis &amp; Compression Fr</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dilated Cardiomyopathy</b> <b>Osteoporosis &amp; Compression Fr</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas B. O'Brien, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2 Cokesbury Drive Suite 204 Fordsville MD 21030</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 20 '91</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21696

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kenneth A. Townsend, Sr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 24 1991</b>		3. TIME OF DEATH <b>6:50 a M</b>	
4. SOCIAL SECURITY NUMBER <b>085-12-0763</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>68</b> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>9-26-1922</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Shad Point Md</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>		9c. COUNTY OF DEATH <b>Wicomico</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Wicomico</b>		10c. CITY, TOWN OR LOCATION <b>Salisbury</b>		10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>	
10e. STREET AND NUMBER <b>1915 Kingswood Dr.</b>				10f. ZIP CODE <b>21801</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>WWII U.S.A.F.</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12</b> Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Security</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Guard</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Atwood Arthur Townsend</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Alda Washburn</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Kenneth A. Townsend Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1915 Kingswood Dr. Salisbury Maryland 21801</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Shad Point Cemetery</b>		20c. LOCATION — City or Town, State <b>Shad Point Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>705 E. Main Street Salisbury Maryland 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Cancer of prostate with wide spread metastasis to bones and lung.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. bones and lung.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic obstructive pulmonary disease. SP bilateral orchiectomy. Severe Anemia, REcurrent Deep Venous Thrombosis</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. Shrestha MD</i>				29c. LICENSE NUMBER <b>D16278</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Shrestha, M.D., Salisbury, MD, 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


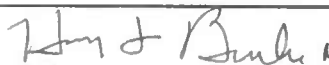
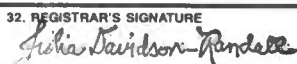
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21697

1. DECEASED'S NAME (First, Middle, Last) <b>JAMES FLETCHER TURNER</b>				2. DATE OF DEATH MONTH <b>7</b> - DAY <b>29</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>12 00 noon</b>					
4. SOCIAL SECURITY NUMBER <b>214-03-8644</b>		5. SEX <b>XX</b> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-21-09</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Route #1 Box 135</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Newburg</b>				9c. COUNTY OF DEATH <b>CHARLES</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Charles</b>		10c. CITY, TOWN OR LOCATION <b>Newburg</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>Route #1 Box 135</b>				10f. ZIP CODE <b>20664</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>11 years</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>							
17. FATHER'S NAME (First, Middle, Last) <b>James Oscar Turner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Millicent Milstead</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Diane G. Bliss</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt 1 Box 135 Newburg, MD 20664</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lee Crematory</b>		20c. LOCATION — City or Town, State <b>Clinton, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>M00173</b>				22. NAME AND ADDRESS OF FACILITY <b>J.H. Eberwein Mortuary La Plata, MD 20646</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death)</b> → <b>Adenocarcinoma of Lung</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> a. <b>Adenocarcinoma of Lung</b> b. <b>Adenocarcinoma of Lung</b> c. <b>Adenocarcinoma of Lung</b> d. <b>Adenocarcinoma of Lung</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>001009</b>				29d. DATE SIGNED (Month, Day, Year) <b>7-29-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Henry L. Burke MD Box 591 La Plata, Maryland 20646</b>											
31. DATE FILED (Month, Day, Year) <b>JUL 30 91</b>				32. REGISTRAR'S SIGNATURE 							

1931



91 21698

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) PEARL ELIZABETH TURNER				2. DATE OF DEATH MONTH DAY YEAR JULY 31, 1991		3. TIME OF DEATH 2:00 A.M. M	
4. SOCIAL SECURITY NUMBER 219-05-6618		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) FEB. 23, 1913	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) AT HOME, 68 SALAMAU CT.		9b. CITY, TOWN OR LOCATION OF DEATH LEXINGTON PARK	
9c. COUNTY OF DEATH ST. MARY'S				10a. STATE MARYLAND		10b. COUNTY ST. MARY'S CO.	
10c. CITY, TOWN OR LOCATION LEXINGTON PARK				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 68 SALAMAU CT.	
10f. ZIP CODE 20653				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7TH. GRADE College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DOMESTIC WORKER		16b. KIND OF BUSINESS/INDUSTRY HOMES	
17. FATHER'S NAME (First, Middle, Last) ELLIOTT TURNER				18. MOTHER'S NAME (First, Middle, Maiden Surname) HENRIETTA SHORTER			
19a. INFORMANT'S NAME (Type/Print) THEODORE W. CRAFTON				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 57 SALAMAU CT., LEXINGTON PARK, MD. 20653			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ST. LUKES METHODIST 8/03/91		20c. LOCATION — City or Town, State SCOTLAND, MARYLAND	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael B. Gardiner</i>				22. NAME AND ADDRESS OF FACILITY MATTINGLEY-GARDINER FUNERAL HOME, P.A. P.O. BOX 270, LEONARDTOWN, MARYLAND 20650			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic Lung Cancer</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death 5 mo	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) 2/91		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED CA Lung			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Fred G. Barr MD</i>				29c. LICENSE NUMBER 022775		29d. DATE SIGNED (Month, Day, Year) 1/31/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Fred G. BARR MD. 5454 Wisconsin Ave Chevy Chase MD 20015							
31. DATE FILED (Month, Day, Year) AUG 02 '91				32. REGISTRAR'S SIGNATURE <i>L. Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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FOR COLDEN

91 21699

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ORA B. TWIGG</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 24, 1991</b>		3. TIME OF DEATH M <b>2:30P</b>	
4. SOCIAL SECURITY NUMBER <b>183-44-0093</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/25/1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>Route 8, Box 203, Valley Road</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John William Wertz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rebecca Ellen Bennett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gerald R. Twigg</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt. 8, Box 228 Valley Road Cumberland, MD</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion Memorial Park</b>		20c. LOCATION — City or Town, State <b>7-27-91 Cumberland, MD 21502</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home</b> <b>108 Virginia Avenue Cumberland, MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>MI</b> <b>CHF</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Poonai</b>				29c. LICENSE NUMBER <b>D 36766</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Poonai 955 Frederick Street, Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 26 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21700

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY J ANET TAYLOR				2. DATE OF DEATH MONTH DAY YEAR 07 26 91		3. TIME OF DEATH 07:42 AM M	
4. SOCIAL SECURITY NUMBER 214-22-0595		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 66 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07-23-1925	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION		9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE	
9c. COUNTY OF DEATH A.A. COUNTY				10a. STATE MARYLAND		10b. COUNTY ANNE ARUNDEL	
10c. CITY, TOWN OR LOCATION SEVERNA PARK				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 13 St. Andrews Crossover	
10f. ZIP CODE 21146				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: CAUCASIAN	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12+ College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY HOME	
17. FATHER'S NAME (First, Middle, Last) RAYMOND ECKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY JANET SLONACKER			
19a. INFORMANT'S NAME (Type/Print) MR. WILLIAM BRUCE TAYLOR				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 13 St. ANDREWS CROSS OVER SEVERNA PK, MD 21146			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		20c. LOCATION — City or Town, State DATE 7/27 BALTIMORE, MD 21146	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Ravenna</i>				22. NAME AND ADDRESS OF FACILITY BARRANCO & SONS FUNERAL HOME SEVERNA PARK, MARYLAND 21146			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metabolic Encephalopathy</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Hemorrhagic Pancreatitis</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Renal Failure</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Respiratory Failure</u> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Essential Hypertension</u> <u>Hepatic Failure</u> <u>Osteoarthritis</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert B. Kroopnick M.D.</i>				29c. LICENSE NUMBER D14757		29d. DATE SIGNED (Month, Day, Year) 7/26/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ROBERT B. KROOPNICK, M.D./95 AQUAHART ROAD, #203/GLEN BURNIE, MARYLAND 21061							
31. DATE FILED (Month, Day, Year) JUL 30 1991				32. REGISTRAR'S SIGNATURE <i>J. A. Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Annabelle Tuck		2. DATE OF DEATH MONTH DAY YEAR 07 - 28 - 91		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER 217-20-9467	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 41 YRS.	7. DATE OF BIRTH (Month, Day, Year) 01-04-19	8. BIRTHPLACE (State or Foreign Country) Maryland
9a. FACILITY NAME (If not institution, give street and number) 27 Rol Park Trailer Village		9b. CITY, TOWN OR LOCATION OF DEATH Millersville		9c. COUNTY OF DEATH Anne Arundel
RESIDENCE OF DECEDENT				
10a. STATE MD	10b. COUNTY Anne Arundel	10c. CITY, TOWN OR LOCATION Millersville		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER 27 Rol Park Trailer Village		10f. ZIP CODE 21108	10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Plastic
17. FATHER'S NAME (First, Middle, Last) Jefferson Nathaniel Gover		18. MOTHER'S NAME (First, Middle, Maiden Surname) Mable Hanna		
19a. INFORMANT'S NAME (Type/Print) Larry Tuck		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 936 Parkey Road, Gambrills, MD 21054		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Glen Haven Cemetery		20c. LOCATION — City or Town, State Glen Burnie, MD
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Thomas A Hardesty		22. NAME AND ADDRESS OF FACILITY Hardesty Funeral Home, P.A. 851 Annapolis Road, Gambrills, MD		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute myocardial infarction DUE TO (OR AS A CONSEQUENCE OF) A.S.H.D. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Hypertension c. Hyperlipidemia d. Venous insufficiency, both legs PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Active alcoholic Type II, diabetes mellitus				Approximate Interval Between Onset and Death
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) N/A	28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER Benjamin A. deGuzman, M.D.		29c. LICENSE NUMBER DD3648		29d. DATE SIGNED (Month, Day, Year) 07-29-91
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Benjamin A. deGuzman, MD PA 1720 Crain Hwy., S. Suite 204 MD 21061				
31. DATE FILED (Month, Day, Year) JUL 30 1991		32. REGISTRAR'S SIGNATURE John Davidson		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**IMPORTANT:** If Item 28 is marked, or Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DECEDENT'S NAME (First, Middle, Last)						DATE OF DEATH		TIME OF DEATH					
Otis Robert Thomas						7 - 18 - 91		11:40 P.M.					
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
222-03-9898		1 M 2 F	71 YRS.	MONTHS DAYS		HOURS MIN.		11-19-19		Va			
9a. FACILITY NAME (If not institution, give street and number)						9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
321 Charles Street						Salisbury				Wico			
RESIDENCE OF DECEDENT													
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?					
md		wico		Salisbury				1 YES 2 NO					
10e. STREET AND NUMBER						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?					
321 Charles Street						21801		U.S.A.					
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.)				14. RACE — American Indian, Black, White, etc.					
1 Never Married 2 Married 3 Widowed 4 Divorced		1 YES 2 NO		1 YES 2 NO Specify:				Specify: BIK					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (9-12) College (1-4 or 5 +) 3rd.				City of Salisbury				Trash Truck					
17. FATHER'S NAME (First, Middle, Last)						18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Charles Thomas						Katie Shepherd							
19a. INFORMANT'S NAME (Type/Print)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Violet Beckett Thomas						321 Charles Street Salisbury, md							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State									
1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)		Jhon Wesley Cemeter.		Westover, md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE						22. NAME AND ADDRESS OF FACILITY							
						LEWIS N. WATSON Funeral Home West Rd. Salisbury, md.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
a. Cardio pulmonary Arrest DUE TO (OR AS A CONSEQUENCE OF):										6 min.			
b. Carcinoma metastatic to lung DUE TO (OR AS A CONSEQUENCE OF):										3 mos.			
c. Carcinoma of Rectum DUE TO (OR AS A CONSEQUENCE OF):													
d.													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? 1 YES 2 NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 YES 2 NO										26. PLACE OF DEATH (Check only one) HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 Natural 5 Pending Investigation 2 Accident 6 Could not be determined 3 Suicide 4 Homicide				M		1 YES 2 NO							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER 1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)					
Robert J. Reilly mo						DZ4986		7/22/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
Robert J. Reilly 560 Riverstone Dr. Salisbury md.													
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE											
JUL 22 91													

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**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

OHMH-18 Rev 1/89



DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21704					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEASED'S NAME (First, Middle, Last) <u>John Richard Valentine</u>				2. DATE OF DEATH MONTH <u>7</u> DAY <u>24</u> YEAR <u>91</u>				3. TIME OF DEATH <u>8 15</u> P M					
4. SOCIAL SECURITY NUMBER <u>212-24-1782</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>63</u> YRS.		IF UNDER 1 YEAR MONTHS <u>  </u> DAYS <u>  </u>		IF UNDER 24 HRS. HOURS <u>  </u> MIN. <u>  </u>		7. DATE OF BIRTH (Month, Day, Year) <u>6 16 28</u>		8. BIRTHPLACE (State or Foreign Country) <u>MD</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>University of Maryland Hospital</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore City</u>				9c. COUNTY OF DEATH <u>  </u>					
10a. STATE <u>MD</u>		10b. COUNTY <u>Allegany</u>		10c. CITY, TOWN OR LOCATION <u>Cumberland</u>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <u>10827 Mexico Farms Road</u>				10f. ZIP CODE <u>21502</u>				10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>1-11-1946--4-16-1947</u>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <u>  </u>				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>					
15. DECEASED'S EDUCATION (Specify only highest grade completed) <u>Secondary</u>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>Factory Employee</u>				16b. KIND OF BUSINESS/INDUSTRY <u>Glass Plant</u>					
17. FATHER'S NAME (First, Middle, Last) <u>John Frederick Valentine</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Hazel Alma Lancaster</u>									
19a. INFORMANT'S NAME (Type/Print) <u>Ruth E. Valentine</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>10827 Mexico Farms Road Cumberland, MD 21502</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <u>  </u>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Rocky Gap Veterans Cem. 7-29-91</u>		DATE <u>  </u>		20c. LOCATION — City or Town, State <u>Cumberland, MD</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>James J. Scarpelli</u>				22. NAME AND ADDRESS OF FACILITY <u>Scarpelli Funeral Home</u> <u>108 Virginia Avenue Cumberland, MD 21502</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Ventricular fibrillation</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>Hypotension</u> b. <u>Intestinal bleeding</u> c. <u>acute leukemia</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST d. <u>  </u>								Approximate Interval Between Onset and Death <u>5 min</u> <u>12 hrs</u> <u>2 weeks</u> <u>2 years</u>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Acute renal failure</u> <u>Pancytopenia secondary to chemotherapy</u> <u>Alloimmunization to platelets</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <u>  </u>									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <u>  </u>		28b. TIME OF INJURY <u>  </u> M <u>  </u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <u>  </u>					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <u>Laurence Austin Doyle MD</u>				29c. LICENSE NUMBER <u>023809</u>		29d. DATE SIGNED (Month, Day, Year) <u>7/24/91</u>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Laurence Austin Doyle MD</u>													
31. DATE FILED (Month, Day, Year) <u>JUL 26 1991</u>				32. REGISTRAR'S SIGNATURE <u>Jake Davidson-Randall</u>									

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma R. Vanbruen</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 26 1991</b>		3. TIME OF DEATH <b>7:50 a M</b>	
4. SOCIAL SECURITY NUMBER <b>194-20-8302</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-10-19</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Coatesville PA.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Deer's Head Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Salisbury</b>	
9c. COUNTY OF DEATH <b>Wicomico</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Wico</b>	
10c. CITY, TOWN OR LOCATION <b>Salisbury</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1514 Biverside Dr Apt 311</b>	
10f. ZIP CODE <b>21801</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Blk</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th</b> College (14 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Herbert A. Johnson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary P. Johnson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Verley Vanbruen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1514 Biverside Dr Apt 311 A</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Evergreen Cement Coatesville, P.A.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Watson Funeral Home West Rd. Salisbury MD 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Malignant Cachexia</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Disseminated Mycosis fungoides with involvement of Liver,</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Lungs, and abdominal wall. MRSA, sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>M. Shrestha MD</b>				29c. LICENSE NUMBER <b>D16278</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/26/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Shrestha, M.D. Deer's Head Center, Salisbury, MD 21801</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ASERENE LAVERNE WEST</b>				2. DATE OF DEATH MONTH DAY YEAR <b>7/23/91</b>		3. TIME OF DEATH <b>11.30AM</b> M	
4. SOCIAL SECURITY NUMBER <b>215 86 9749</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>39</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 25, 1952</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>PRINCE GEORGE HOSP CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>CHEVERLY</b>	
9c. COUNTY OF DEATH <b>PRINCE GEORGE'S</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Prince George's</b>	
10c. CITY, TOWN OR LOCATION <b>Cheverly</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6008 Reed Street</b>	
10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>GRAD SEC - 12</b> College (1-4 or 5+) <b>VOCATIONAL-1</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Private Duty Nurse</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Nursing</b>	
17. FATHER'S NAME (First, Middle, Last) <b>George Birdsong</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Gonder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia Birdsong</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2119 G Coosawattee, Atlanta, GA 30319</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 7/25/91</b>		20c. LOCATION — City or Town, State <b>Landover, MD</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles C. Shiggy</b>	
22. NAME AND ADDRESS OF FACILITY <b>House of Diggs Mortuary 4906 Iverson Pl., Hillcrest Hts., MD</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>anoxic encephalopathy</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>drug overdose, presumed</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Beverly F. Gilder, M.D.</b>				29c. LICENSE NUMBER <b>D40826</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Beverly F. Gilder, M.D. 7500 Hanover Parkway, Greenbelt MD 20770</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 '91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, & 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>LEON ELMER WILLIAMS</b>								2. DATE OF DEATH MONTH <b>JULY</b> DAY <b>16</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>12:45 P M</b>							
4. SOCIAL SECURITY NUMBER <b>183-24-4436</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-18-28</b>		8. BIRTHPLACE (State or Foreign Country) <b>Rodney, Miss.</b>									
9a. FACILITY NAME (If not institution, give street and number) <b>MALCOLM GROW USAF MEDICAL CENTER</b>								9b. CITY, TOWN OR LOCATION OF DEATH <b>ANDREWS AFB MD</b>				9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>							
10a. STATE <b>D.C.</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Washington</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>3857 Halley Terrace, S.E.</b>								10f. ZIP CODE <b>20032</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Nov. 1951</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Corrections Officer</b>				16b. KIND OF BUSINESS/INDUSTRY <b>D.C. Dept. of Corrections</b>											
17. FATHER'S NAME (First, Middle, Last) <b>Otis Williams</b>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Etta Williams</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Williams</b>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3857 Halley Terrace, S.E. Wash., DC 20032</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arlington Cemetery</b>				20c. LOCATION — City or Town, State <b>Arlington, Virginia</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Phillip Bell</i>				739				22. NAME AND ADDRESS OF FACILITY <b>Robert G. Mason Funeral Home, Inc. 1661 Good Hope Road, S.E. Wash., DC 20020</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GASTRIC CANCER WITH METASTASES</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
				28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28e. DESCRIBE HOW INJURY OCCURED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Charles E. Morris</i>								29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <b>JULY 16, 1991</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHARLES E. MORRIS, CAPTAIN, USAF, MC</b> <b>MALCOLM GROW USAF MEDICAL CENTER</b> <b>ANDREWS AFB, MD 20331-5300</b>																			
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>															

TOPICS 12

REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

OHMH-16 Rev 1/89

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jean L. Walker</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 29, 1991</b>		3. TIME OF DEATH <b>2 AM</b>	
4. SOCIAL SECURITY NUMBER <b>227 05 1575 D</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12/7/10</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3821 Nassawango Hills Drive</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Snow Hill</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Snow Hill</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>200 Ironshire Street</b>				10f. ZIP CODE <b>21863</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Rufus Shaw</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amanda Keith</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Sylvia W. Shumate</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3821 Nassawango Hills Dr., Snow Hill, Md. 21863</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Bates Methodist Cemetery</b>		20c. LOCATION — City or Town, State <b>Snow Hill, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Dennis Funeral Home</b> <b>110 Franklin St., Snow Hill, Md. 21863</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Hypertensive cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  <b>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.</b> <b>Diabetes</b>						Approximate Interval Between Onset and Death <b>15 yrs</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D05865</b>		29d. DATE SIGNED (Month, Day, Year) <b>07-30-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Robert C. LaMar, M.D., 104 N. Bay St., Snow Hill, Md. 21863</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 31 91</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>IRENE WOODWARD</b>				2. DATE OF DEATH MONTH <b>07</b> - DAY <b>27</b> - YEAR <b>91</b>				3. TIME OF DEATH <b>11:45A</b>	
4. SOCIAL SECURITY NUMBER <b>219-34-0024</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7. DATE OF BIRTH (Month, Day, Year) <b>06-11-07</b>				8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>REISTERSTOWN</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>335 HIGH FALCON ROAD</b>				10f. ZIP CODE <b>21136</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Daniel M. Forsythe</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ella E. Sweithzer</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. David M. Woodward Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>335 Highfalcon Rd. Reisterstown, Md. 21136</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Greenlawn Memorial Cem. 7/30/91 Williamsport, Md.</b>				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Eline Funeral Home Reisterstown, Md. 21136</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerosis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multiple CVA's</b>								Approximate Interval Between Onset and Death <b>1 day</b> <b>years</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D-12990</b>				29d. DATE SIGNED (Month, Day, Year) <b>7/28/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James A. Quinlan Jr MD 7801 York Rd Towson, MD 21204</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 29 '91</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <u>BXXXX KXXXXX BRIAN EDWARD WILLEY</u>				2. DATE OF DEATH MONTH <u>7</u> DAY <u>26</u> YEAR <u>91</u>		3. TIME OF DEATH <u>3:50P</u> M									
4. SOCIAL SECURITY NUMBER <u>212-04-9658</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>21</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>11-19-1969</u>		8. BIRTHPLACE (State or Foreign Country) <u>Maryland</u>							
9a. FACILITY NAME (If not institution, give street and number) <u>University of Maryland</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>Baltimore</u>				9c. COUNTY OF DEATH <u>Baltimore</u>							
10a. STATE <u>Maryland</u>		10b. COUNTY <u>Dorchester</u>		10c. CITY, TOWN OR LOCATION <u>Linkwood</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <u>3859 Vincent Road</u>				10f. ZIP CODE <u>21835</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>									
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>White</u>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>12 Years</u> College (1-4 or 5+) <u>College</u>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>student</u>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <u>Thomas Edward Willey</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Katherine Moxey</u>											
19a. INFORMANT'S NAME (Type/Print) <u>Thomas Edward Willey</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>PO Box 82 Linkwood, Maryland 21835</u>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Lady of Good Counsel</u>		DATE <u>7-29</u>		20c. LOCATION — City or Town, State <u>Secretary, Maryland</u>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Kenneth L. Thomas</u>				22. NAME AND ADDRESS OF FACILITY <u>Thomas Funeral Home</u> <u>700 Locust St. Cambridge, Maryland</u>				21613							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>ARDS</u> DUE TO (OR AS A CONSEQUENCE OF): a. <u>Adenovirus pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Chemotherapy induced granulocytopenia</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>Recurrent medulloblastoma</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>Staph aureus pneumonia</u> <u>Sepsis syndrome</u>								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Staph aureus pneumonia</u> <u>Sepsis syndrome</u>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <u>P. Blum MD</u>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>7/26/91</u>									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Philip Blum MD 22 S. Greene St. Baltimore, MD 21231</u>												31. DATE FILED (Month, Day, Year) <u>7/26/91</u>		32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Randall</u>	

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NOTED

For the purpose of the  
investigation, the following  
information is being furnished:

1. Name of the person

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BERTHA M WALKER</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:07 A M</b>	
4. SOCIAL SECURITY NUMBER <b>213-42-2402</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-5-43</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIV. OF MD.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>WI</b>		10c. CITY, TOWN OR LOCATION <b>TYASKIN</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>RT. I BOX 603</b>				10f. ZIP CODE <b>21805</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11+2</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>State employee</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Deer Head State Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MARVIN DICKERSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARION DICKERSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>R. DAVID ANDERSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>UNIV. OF MD. 22 S. GREENE ST., BALTO, MD. 21201</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>DATE</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James N. Watson Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>WATSON Funeral Home West Rd. Salisbury, Md. 21801</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Restrictive Cardiac Disease - Amyloid</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Liver Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Renal Failure</b> Approximate Interval Between Onset and Death: <b>1 year</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Asthma</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. David Anderson</b>				29c. LICENSE NUMBER <b>D36885</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-22-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>R. DAVID ANDERSON UNIV. OF MD., 22 S. GREENE ST., BALTO, MD. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 24 '91</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 21713

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLOYD WINTERS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 23, 1991</b>		3. TIME OF DEATH <b>6:55 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-10-1509</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-08-09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>	
9c. COUNTY OF DEATH <b>Allegany</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>Allegany</b>	
10c. CITY, TOWN OR LOCATION <b>Cumberland</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>107 Grand Ave.</b>	
10f. ZIP CODE <b>21502</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Boiler room worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B&amp;O Railroad</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Lloyd A. Winters</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mae</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ginger I Ser</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1103 Lexington Ave Cumb MD 21502</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hillcrest Burial Park 7-26-91</b>		20c. LOCATION — City or Town, State <b>Cumb. MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James F. Scarpelli</b>				22. NAME AND ADDRESS OF FACILITY <b>Scarpelli Funeral Home 108 Virginia Ave. Cumberland MD 21502</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Respiratory failure</b> DUE TO (OR AS A CONSEQUENCE OF): Severely Chronic Obstructive Lung Disease Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Congestive Heart failure</b>							Approximate Interval Between Onset and Death <b>days</b> <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive Heart failure</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Sunil Gupta</b>				29c. LICENSE NUMBER <b>D 33280</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/24/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Sunil Gupta, Memorial Hospital Medical Bldg., Cumberland, MD 21502</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 25 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

31 51113



91 21714

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARL LESLIE WEBER</b>				2. DATE OF DEATH MONTH <b>JULY</b> DAY <b>24</b> , YEAR <b>1991</b>				3. TIME OF DEATH <b>1:48 P M</b>				
4. SOCIAL SECURITY NUMBER <b>213 09 6599</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>87</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>June 3, 1904</b> Md		8. BIRTHPLACE (State or Foreign Country)						
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND</b>			9c. COUNTY OF DEATH <b>ALLEGANY</b>					
10a. STATE <b>Md</b>		10b. COUNTY <b>Allegany</b>		10c. CITY, TOWN OR LOCATION <b>(Bel Air) Cumberland, Md.</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>114 Winslow St.</b>				10f. ZIP CODE <b>21502</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>						
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>0</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Coal Miner</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Coal</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Charles Weber</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Boag</b>								
19a. INFORMANT'S NAME (Type/Print) <b>Marion Tibbetts</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 Winslow St. (Bel Air) Cumberland, Md. 21502</b>								
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Frostburg Mem. Park 7-27-91 Frostburg, Md.</b>			20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. McKenzie</i>				22. NAME AND ADDRESS OF FACILITY <b>Eichhorn-McKenzie Funeral Home Lonaconing, Md. 21539</b>								
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>3 days</b>												
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Parkinsonism, gastrointestinal bleeding Coronary atherosclerosis, Arteriosclerosis</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												
29b. SIGNATURE AND TITLE OF CERTIFIER <i>George Breza MD</i>						29c. LICENSE NUMBER <b>012532</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/25/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. GEORGE BREZA, M.D., BMG, 912 SETON DRIVE, CUMBERLAND, MD 21502</b>												
31. DATE FILED (Month, Day, Year) <b>JUL 29 1991</b>				32. REGISTRAR'S SIGNATURE <i>John A. ...</i>								

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



ITEM:15 per INFORMANT  
G-679 9/9/91 cm

91 21715

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY L. WALLACE</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>22</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0622 M</b>			
4. SOCIAL SECURITY NUMBER <b>413-18-2524</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05 20 16</b>		8. BIRTHPLACE (State or Foreign Country) <b>Tenn.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>AA MC Arne Arundel Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Annapolis</b>			9c. COUNTY OF DEATH <b>Anne Arundel</b>		
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Arnold</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1 Sheridan Road</b>				10f. ZIP CODE <b>21012</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Caucasian</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12+ College (1-4 or 5+) 4yrs</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Executive Secretary</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Nevamar Corpotation</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Charles W. Lusk</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Harriett Johnson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MR. RICHARD H. WALLACE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1 Sheridan Road Arnold, Maryland 21012</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory Baltimore</b>			20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James E. Barranco</i>				22. NAME AND ADDRESS OF FACILITY <b>Barranco &amp; Sons Funeral Home 495 Ritchie Highway Severna Park, MD 21146</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>congestive heart failure</b> DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cancer of @ lungs</b>							Approximate Interval Between Onset and Death		
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John B. Lowery MD</i>				29c. LICENSE NUMBER <b>D18529</b>		29d. DATE SIGNED (Month, Day, Year) <b>22 July 91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John B. Lowery MD 600 Lybely Ave, Annapolis MD 21401</b>									
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 SEP 12

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert William Ernest</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>28</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:07 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-76-3755</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-11-58</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>North Arundel Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>		9c. COUNTY OF DEATH <b>Anne Arundel</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>8533 Neptune Dr.</b>			
10f. ZIP CODE <b>21122</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Carpenter</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Robert L. Ernest</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Audrey A. Benson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Deborah M. Ernest</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8533 Neptune Dr. Pasadena, Md. 21122</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Cemetery 8-1-91</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Stallings Funeral Home PA. 3111 Mountain Rd. Pasadena, Md. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MULTIPLE TRAUMAS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>7-28-91</b>		28b. TIME OF INJURY <b>7:08P M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Driver in motor cycle auto impact</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Street</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Glen Burnie Anne Arundel Co.</b>		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>July 29, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Margarita A. Korell M.D. 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b> 32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GUY E. WASHINGTON</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>2:50 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-42-8269</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-03-46</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ANNE ARUNDEL GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ANNAPOLIS</b>		9c. COUNTY OF DEATH <b>ANNE ARUNDEL</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>AA CO.</b>		10c. CITY, TOWN OR LOCATION <b>SHADY SIDE</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>4806 ATWELL RD</b>		10f. ZIP CODE <b>20867</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>US</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1970's</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				17. FATHER'S NAME (First, Middle, Last) <b>ALBERT WASHINGTON</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE MATTHEWS</b>	
19a. INFORMANT'S NAME (Type/Print) <b>NANCY WASHINGTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>909-D ROYAL ST., ANNAPOLIS, MD 21401</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD VA CEMETERY</b>		20c. LOCATION — City or Town, State <b>7-29-91 CROWNSVILLE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Larry H. Reese</i>				22. NAME AND ADDRESS OF FACILITY <b>REESE AND SONS MORTUARY, P.A. 821 WEST ST., ANNAPOLIS, MD 21401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE INJURIES COMPLICATING SEIZURE DISORDER</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>Fell From Tree</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Friends Home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1453 Halie Dr. Anne Arundel Co.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle, Jr.</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>07 25 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE, JR., MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>JUL 30 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANKLIN</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>11</b> YEAR <b>91</b>				3. TIME OF DEATH <b>0510</b>		
4. SOCIAL SECURITY NUMBER <b>221-12-5375</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR 12, 1924</b>		8. BIRTHPLACE (State or Foreign Country) <b>SEAFORD, DE</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>		
10a. STATE <b>MD</b>			10b. COUNTY <b>UNK</b>		10c. CITY, TOWN OR LOCATION <b>VIENNA</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>RT 1, BOX #31</b>					10f. ZIP CODE <b>21869</b>			10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABORER</b>			16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>				
17. FATHER'S NAME (First, Middle, Last) <b>VICTOR WOOLFORD</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BLANCHE SHELTON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>OLEN L. BRUMBLE</b>					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>ONE CHANDLER ST, SEAFORD, DE 19973</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MACEDONIA</b>			DATE <b>7/15/91</b>		20c. LOCATION — City or Town, State <b>SEAFORD, DE</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles E. Young</i>					22. NAME AND ADDRESS OF FACILITY <b>YOUNG's, 308 N. FRONT ST, SEAFORD, DE 19973</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Metastatic Carcinoma of the Prostate</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate interval Between Onset and Death <b>2 years</b>		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James E. Martin, M.D.</i>					29c. LICENSE NUMBER <b>030690</b>			29d. DATE SIGNED (Month, Day, Year) <b>7/11/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James E. Martin, M.D., 145 E. Carroll St., Salisbury, Md.</b>										
31. DATE FILED (Month, Day, Year) <b>JUL 22 91</b>										

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR 91-4328-047  
1 - STATE REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>PHONEXAY XAIYAVATH</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>26</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:00P</b> M	
4. SOCIAL SECURITY NUMBER <b>577-06-5143</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>29</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>April 4 1962</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Laos</b>		9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>SAULSBURY</b>		9c. COUNTY OF DEATH <b>WORCESTER</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Showell</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>P.O. Box 114</b>		10f. ZIP CODE <b>21862</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>Asian</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Asian</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Poultry</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Chris Sinthavong</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt.1 Box 458, Delmar, DE 19940</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>Sunset Memorial Park 8-3-91</b>		20c. LOCATION — City or Town, State <b>Berlin, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles W. [Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Hastings Funeral Home, Selbyville, DE</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple injuries</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>07 27 1991</b>		28b. TIME OF INJURY <b>12:35P</b> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>DRIVER IN AUTO/AUTO IMPACT</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>PUBLIC HIGHWAY</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>SHOWELL</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>07 27 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. M. Dixon 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>07 30 91</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21720

1. DECEDENT'S NAME (First, Middle, Last) <b>John Edward Young, Jr.</b>			2. DATE OF DEATH MONTH <b>7</b> DAY <b>29</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:55P</b> M
4. SOCIAL SECURITY NUMBER <b>214-30-2755</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 24, 1935</b>
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>HARFORD Memorial Hospital</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>HARFORD</b>		9c. COUNTY OF DEATH <b>HARFORD</b>
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Harford</b>		10c. CITY, TOWN OR LOCATION <b>Darlington</b>
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4105 Conowingo Road</b>			10f. ZIP CODE <b>21034</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supply Clerk</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto Parts</b>
17. FATHER'S NAME (First, Middle, Last) <b>John Edward Young, Sr.</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha E. Riley</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Betty J. Young</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4105 Conowingo Road, Darlington, Md. 21034</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion U. M. Cemetery 8-1-91</b>		20c. LOCATION — City or Town, State <b>Bel Air, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Howard K. McComas III</b>			22. NAME AND ADDRESS OF FACILITY <b>Howard K. McComas III Funeral Home, P.A. 1317 Cokesbury Road, Abingdon, Md. 21009</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>CIRRHOSIS OF LIVER</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>a. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>GI Bleeding</b> <b>Anemia</b>					
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dante M. Monakill</b>			29c. LICENSE NUMBER <b>PD7644</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/30/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DANTE U. MONAKILL MD HARFORD Md 21078</b>					
31. DATE FILED (Month, Day, Year) <b>JUL 31 1991</b>		32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randall</b>			

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>JOHN M AM STADT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 03 1991</b>		3. TIME OF DEATH H M <b>17:53 M</b>	
4. SOCIAL SECURITY NUMBER <b>522-32-8284</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-29-15</b>	
8. BIRTHPLACE (State or Foreign Country) <b>USA-WISCONSIN</b>				9a. FACILITY NAME (If not institution, give street and number) <b>LA HARFORD MEMORIAL HOSP</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>HARFORD</b>	
9c. COUNTY OF DEATH <b>HARFORD</b>				10a. STATE <b>VA</b>		10b. COUNTY <b>Fairfax Co.</b>	
10c. CITY, TOWN OR LOCATION <b>McLEAN</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>		10e. STREET AND NUMBER <b>6712 WEAVER AVENUE</b>	
10f. ZIP CODE <b>22101</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES <b>WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ACCOUNTANCY</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ACCOUNTANT</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Michael Amstadt</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Bittner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Ruth N. Amstadt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6712 Weaver Avenue, McLean, VA 22101</b>			
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>National Memorial Park 8-7-91 Falls Church, VA</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Murphy Falls Church Funeral Home, 1102 W. Broad St, Falls Church, VA</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE CORONARY ARTERY DISEASE 1 HR</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. <b>A SCVD.</b> c. <b>HYPERCHOLESTEROLEMIA</b> d. <b>HYPERTENSION</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>HYPERTENSION</b>						24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 XER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify) ER HOSPITAL</b>			
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>NA M</b>	
28c. INJURY AT WORK? <b>1 YES 2 NO</b>				28d. DESCRIBE HOW INJURY OCCURRED <b>NA</b>		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>NA</b>	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>		29c. LICENSE NUMBER <b>D 21809</b>	
29d. DATE SIGNED (Month, Day, Year) <b>08-03-91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.S. PRABHU 1810 BELAIR RD #102 FALLS CHURCH VA 22047</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21722			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEASED'S NAME (First, Middle, Last) JOAN M. BARGER				2. DATE OF DEATH MONTH DAY YEAR AUG 8, 1991				3. TIME OF DEATH 2:15 P. M.			
4. SOCIAL SECURITY NUMBER 216 32 2627		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 54 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) APRIL 4, 1937		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) 11004 GATE VIEW ROAD				9b. CITY, TOWN OR LOCATION OF DEATH LOCKEYSVILLE				9c. COUNTY OF DEATH BALTIMORE			
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION LOCKEYSVILLE				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 11004 GATE VIEW ROAD				10f. ZIP CODE 21030				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) PATIENT RELATIONS SUP.				16b. KIND OF BUSINESS/INDUSTRY ST. JOSEPH HOSPITAL			
17. FATHER'S NAME (First, Middle, Last) STEPHEN J. WOODEN				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA A. STAPLES							
19a. INFORMANT'S NAME (Type/Print) FAMILY RECORDS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS ABOVE							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DULANEY VALLEY MNG GR 8-10		DATE 8-10		20c. LOCATION — City or Town, State TIMONIUM, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE [Signature]				22. NAME AND ADDRESS OF FACILITY EVANS CHAPEL OF CHIMES 2325 YORK ROAD - TIMONIUM							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Chemia</u> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Metastatic colon cancer</u> c. d. Approximate Interval Between Onset and Death ~ 2 wks. ~ 3 yrs.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]				29c. LICENSE NUMBER D16587				29d. DATE SIGNED (Month, Day, Year) AUG 9, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR PAUL CHANG 5601 Loch Raven Blvd. BALTO. MD											
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

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91 21723

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>BEN HEAVER BOLDEN</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>06</b> YEAR <b>91</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>218 36 3329</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02 04 38</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>CHURCH HOME HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>102 N CENTRAL AVE</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>BENJAMIN RICHARDSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GEORGIANNE BOLDEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ELLA MAE BOLDEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>102 N. CENTRAL AVE/BALTIMORE, MD 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>VENTRICULAR FIBRILLATION</b>							
a. <b>NOT KNOWN - DEAD ON ARRIVAL</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D36974</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 06 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID NYANJOM M.D. CHURCH HOME HOSPITAL 100N BROADWAY BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21724

1. DECEDENT'S NAME (First, Middle, Last) <b>ANNIE YVONNE BLOOM</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 5, 1991</b>		3. TIME OF DEATH <b>4:30 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>090-14-7283</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>84 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>FEB. 28, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>		9a. FACILITY NAME (If not institution, give street and number) <b>MONTGOMERY COUNTY GENERAL HOSP.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>OLNEY</b>		9c. COUNTY OF DEATH <b>MONTGOMERY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6404 APOLLO DR., APT. C</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>TEACHER</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SOLOMON STEINBERG</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RACHAEL MEDELOFF</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RICHARD BLOOM</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>14220 ANSTED RD. SILVER SPRING, MD 20905</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 6 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESED 8/7/91</b>		20c. LOCATION — City or Town, State <b>ROSEDALE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. MULTISYSTEM FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>FRACTURE RIGHT HIP</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>7/7/91</b>		28b. TIME OF INJURY <b>2 A M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>FELL FROM BED</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>MERIDIAN NURSING HOME</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>LAYHILL, MD</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>208546</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-6-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John Tauber MD 8218 W. S. Conner Ave</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Alex Booze</b>				2. DATE OF DEATH MONTH DAY <b>8-7-1991</b>		3. TIME OF DEATH <b>5:15 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-22-6558</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-18-08</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Durham, N.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County General Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Rundallstown</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Balto, MD</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2403 Westwood Avenue</b>	
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Western Electric</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Industrial</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Clarence Binahm</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Stone</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mildred Evans</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2403 Westwood Avenue, Balto, MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial PK</b>		20c. LOCATION — City or Town, State <b>Balto, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James G. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>JAMES A. MORTON &amp; SONS F. H. 1701 Laurens St., Balto, MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>D37949</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-7-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>5401 Old Course Road, Randallstown, Maryland, 21133</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-18 Rev 1/89

JWR

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John R. Chichester II</b>				2. DATE OF DEATH MONTH <b>7</b> DAY <b>30</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>365-16-0655</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-2-09</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3519 Reisterstown Rd.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto.</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2810 Reisterstown Rd.</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Groomer Pimlico</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pimlico Racetrack</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John R. Chichester I</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>E. Jane Slaughter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2353 Anoka Ave. 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus</b>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John March</b>				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home 4301 Wabash Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Carcinoma of Larynx with metastases</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>min</b> <b>13 months</b> <b>7 months</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>F.S. Leacock M.D.</b>				29c. LICENSE NUMBER <b>D06812</b>		29d. DATE SIGNED (Month, Day, Year) <b>Aug 8, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>F.S. LEACOCK, M.D. 3502 W. ROGERS AVE BALT, MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Rodwell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that a death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

18 JUL 1957

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21728

1. DECEDENT'S NAME (First, Middle, Last) <i>Esther Chupnick</i>				2. DATE OF DEATH MONTH DAY YEAR <i>Aug 3 1991</i>		3. TIME OF DEATH <i>3:30 PM</i>	
4. SOCIAL SECURITY NUMBER <i>214-16-3429</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>72</i> YRS.	7. DATE OF BIRTH (Month, Day, Year) <i>JUNE 18, 1919</i>		8. BIRTHPLACE (State or Foreign Country) <i>PENNSYLVANIA</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>MERIDIAN NURSING HOME</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>RANDALLSTOWN</i>		9c. COUNTY OF DEATH <i>BALTIMORE</i>	
10a. STATE <i>MARYLAND</i>		10b. COUNTY <i>BALTIMORE</i>		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <i>1004 KINGSTON RD.</i>				10f. ZIP CODE <i>21208</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>Cottage</i>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>ASSESSOR</i>		16b. KIND OF BUSINESS/INDUSTRY <i>MD STATE GOVERNMENT</i>			
17. FATHER'S NAME (First, Middle, Last) <i>SAMUEL GOLDMAN</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>ELLA PLOTNICK</i>			
19a. INFORMANT'S NAME (Type/Print) <i>MRS. HARRIETT EISENBERG</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1004 KINGSTON RD. BALTIMORE, MD 21208</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>BALTIMORE HEBREW 8/4/91</i>		20c. LOCATION — City or Town, State <i>REISTERSTOWN, MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay Alan Lewis</i>				22. NAME AND ADDRESS OF FACILITY <i>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. OVARIAN CANCER</i> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <i>D35606</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/4/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>SAMUEL ZILBER 4000 OLD COURT RD BAL MD 21208</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 9 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>CHERYL C CORBETT</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>06</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1:53 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-56-9411</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>41</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-23-50</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
RESIDENCE OF DECEASED							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore, Maryland</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>20 Wyndmore Place</b>				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Service Rep.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>C&amp;P Telephone Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Eugene Chisolm</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LaRose Hall</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Arthur L. Corbett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1102 West Lafayette Ave, Balto, MD</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King Memorial PK.</b>		DATE <b>8/10/91</b>		20c. LOCATION — City or Town, State <b>Balto, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James G. Morton</i>				22. NAME AND ADDRESS OF FACILITY <b>JAMES A. MORTON &amp; Sons Funeral Home</b> <b>1701-31 Laurens St, Balto, MD 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Respiratory Failure</b>							
b. <b>Breast Cancer</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathy Durham Miller MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>08-06-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kathy D. Miller MD Tower 10 600 N Broadway Baltimore MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 61153

FOX BIVALS



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21730							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>VONDALEER, COUSER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>				3. TIME OF DEATH <b>4:35 P M</b>							
4. SOCIAL SECURITY NUMBER <b>218-44-6677</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>9-6-45</b>		8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>520 N. EDGEWOOD STREET</b>				10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>2-18-65 to 2-16-68</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>				16b. KIND OF BUSINESS/INDUSTRY <b>London Fog</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Marion Couser</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel Wells</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Mabel Couser</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>520 N. Edgewood St. Balto., Md. 21229</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest VA 8-12-91</b>		DATE <b>8-12-91</b>		20c. LOCATION — City or Town, State <b>Owingsmills, Md.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Derrick C. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones Funeral Home 21215 4611 Park Heights Ave. Balto., Md.</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Terminal Lung Cancer &amp; Metastasis</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>U.I.T.</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>4 months</b>															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. E. ... MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ASU WANI YOBORH, ST AGNES HOSP. 900 CATON AVE, BALTO, MD 21229</b>				31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>J. ...</i>							

08715 10

91 21731

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ALLEN CONWAY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:20 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-53-3244</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>45</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-18-1950</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO	
10e. STREET AND NUMBER <b>522 Gold St.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Designer</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Florist</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Oliver Nathaniel Conaway</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ethel Dunlap</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marion D. Conway</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>522 Gold St. Balto., Md. 21217</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Derrick C. Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 15</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY ARREST</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>PROBABLE AIDS</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> <input checked="" type="checkbox"/> Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>5</b> Pending Investigation <b>2</b> Accident <b>6</b> Could not be determined <b>3</b> Suicide <b>7</b> <input type="checkbox"/> <b>4</b> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carlos R. R...</b>				29c. LICENSE NUMBER <b>238299</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CARLOS RABE, MD 101 W. LEAD ST. SUITE 815, BALT., MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <b>[Signature]</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

VISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 51731

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 21732

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Geraldine W. Daniel</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>2</b> YEAR <b>91</b>		3. TIME OF OATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>217-32-7527</b>		5. SEX <b>1</b> <input type="checkbox"/> M <b>2</b> <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-1-35</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>
9a. FACILITY NAME (If not institution, give street and number) <b>4012 Fernhill Ave.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF OATH	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Balto.</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4012 Fernhill Ave.</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Total Health Care</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Waters</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Waters</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rhonda Holsey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4012 Fernhill Ave. 21215</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park</b>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>March Funeral Home 4300 Wabash Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. metastatic colon<sup>rectal</sup> cancer</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Simon Bardin MD</i>				29c. LICENSE NUMBER <b>D25695</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-7-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Simon Bardin Suite 306 4000 OLD COURT RD Balt. Md 21208</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <u>Arthur J. Denisio</u>				2. DATE OF DEATH MONTH <u>8</u> DAY <u>3</u> YEAR <u>91</u>		3. TIME OF DEATH <u>5:20 AM</u>	
4. SOCIAL SECURITY NUMBER <u>218-05-9806</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>72</u> YRS.		7. DATE OF BIRTH Month, Day, Year <u>3-23-19</u>	
8. FACILITY NAME (If not institution, give street and number) <u>Veterans Hospital (Luth Raven)</u>				9. CITY, TOWN OR LOCATION OF DEATH <u>BALTO CITY</u>		10. COUNTY OF DEATH <u>MD.</u>	
10a. STATE <u>PA.</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>AIRVILLE, PA.</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <u>RD 2 204C</u>				10f. ZIP CODE <u>17302</u>		10g. CITIZEN OF WHAT COUNTRY? <u>US</u>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WW II</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>10</u> College (1-4 or 5+) <u>LABORER</u>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>LABORER</u>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <u>Denato Denisio</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>Fusco</u>			
19a. INFORMANT'S NAME (Type/Print) <u>Thelma Denisio</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>RD 2 204C 17302 Airville, PA.</u>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>Green Mount Cem.</u>		20c. LOCATION — City or Town, State <u>BALTO MD.</u>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>Frank J. Deel Ace</u>				22. NAME AND ADDRESS OF FACILITY <u>Della Noce Sons F.H.</u> <u>322 S. HICK ST. BALTO 21202 MD.</u>			
23. PART I. Enter the disease(s), or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Renal Failure</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Sepsis</u> c. <u>Diabetes</u> d. <u>Pulmonary edema</u>							Approximate Interval Between Onset and Death <u>3 weeks</u>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Pulmonary edema</u>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <u>Rose Bright MD</u>
29c. LICENSE NUMBER							29d. DATE SIGNED (Month, Day, Year) <u>8/3/91</u>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Rose Bright</u>							31. DATE OF DEATH (Month, Day, Year) <u>AUG 3 1991</u>
32. REGISTRAR'S SIGNATURE <u>John K. ...</u>							33. REGISTRAR'S SIGNATURE

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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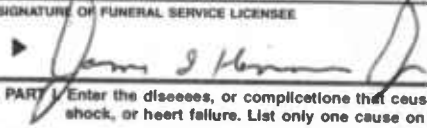

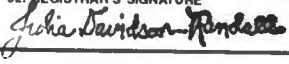
ITEMS:23,27 per ME  
G-678 8/13/91 cm  
91-4502-045

91 21735

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACKIE JAMES DUNSTON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 03 1991</b>		3. TIME OF DEATH <b>9:53 P M</b>					
4. SOCIAL SECURITY NUMBER <b>220-32-2431</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05-20-1936</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>peninsula general hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>				9c. COUNTY OF DEATH <b>WICOMICO</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Somerset</b>		10c. CITY, TOWN OR LOCATION <b>Princess Anne</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>			
10e. STREET AND NUMBER <b>Rt. 2, Box 264S, Dublin Road</b>				10f. ZIP CODE <b>21853</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
11. MARITAL STATUS <b>1 Never Married 2 Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 3 College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer/Mechanic</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Oscar Dunston</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Thelma Hamblin</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Lola A. Dunston</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Rt.2, Box 264S, Princess Anne, Md. 21853</b>							
20a. METHOD OF DISPOSITION <b>1 Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Springhill Memory Ga. 8/7</b>				20c. LOCATION — City or Town, State <b>Hebron, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE  <b>MO0295</b>				22. NAME AND ADDRESS OF FACILITY <b>Hinman FunerAl Home Princess Anne, Md. 21853</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>PULMONARY TUBERCULOSIS, BILATERAL</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>							
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide</b> <b>5 Pending Investigation</b> <b>6 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>				29b. SIGNATURE AND TITLE OF CERTIFIER  <b>FRANK J. PERETTI, M.D.</b>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-5-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANK J. PERETTI, 411 N. PENN STREET BALTIMORE, MARYLAND 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 06 '91</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: A death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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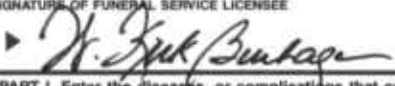


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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEANNE R. DONDERO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 5 1991</b>		3. TIME OF DEATH <b>9:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>141 14 1543</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 13, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Berlin Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Berlin</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
10a. STATE <b>Md</b>				10b. COUNTY <b>Worcester</b>		10c. CITY, TOWN OR LOCATION <b>Ocean City</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>12670 Eagles Nest Road</b>			
10f. ZIP CODE <b>21842</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>11</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Housewife</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Eliot W. Low</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Ada Gwendolyn Luckhurst</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles A. Dondero, III</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P. O. Box 309, Ocean City, Md 21842</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Valleau Cemetery</b>		20c. LOCATION — City or Town, State <b>Ridgewood, NJ</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Burbage Funeral Home 108 Williams St., Berlin, Md. 21811</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div> <p>a. DUE TO (OR AS A CONSEQUENCE OF):</p> <p><b>COPD</b></p> <p>b. DUE TO (OR AS A CONSEQUENCE OF):</p> <p><b>Bronchial Bilateral Pneumonia</b></p> <p>c. DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.</p> </div> <div> <p>Approximate Interval Between Onset and Death</p> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>D02026</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 6, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FEDERICO G. ARTES, M.D., 10622a Ocean Pines, Berlin, Md. 21811</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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item 10e; 8-14-91;  
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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21737

1. DECEDENT'S NAME (First, Middle, Last) Wilmore Carter Emerson		2. DATE OF DEATH MONTH 8 DAY 6 YEAR 91		3. TIME OF DEATH 11:20 PM									
4. SOCIAL SECURITY NUMBER 212-01-5668		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 1, 1918		8. BIRTHPLACE (State or Foreign Country) Maryland					
9a. FACILITY NAME (If not institution, give street and number) Greater Baltimore Medical Center				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore (Towson)				9c. COUNTY OF DEATH Baltimore					
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 537 Allegheny Avenue				10f. ZIP CODE 21204		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) College (1-4 or 5+) Engineer		15b. KIND OF BUSINESS/INDUSTRY Pennsylvania Railroad									
17. FATHER'S NAME (First, Middle, Last) Wilmore Ross Emerson				18. MOTHER'S NAME (First, Middle, Maiden Surname) Florence Elizabeth Carter									
19a. INFORMANT'S NAME (Type/Print) Charlotte E. Emerson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Prospect Hill Cemetery 8/10/91		20c. LOCATION — City or Town, State Towson, Md.									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Wallace S. Brooks				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Arteriosclerotic coronary artery and hypertensive heart disease Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Retroperitoneal hematoma. Metastatic prostate carcinoma.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicida		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Robert A. Palermo		29c. LICENSE NUMBER D27740		29d. DATE SIGNED (Month, Day, Year) 8/7/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Robert A. Palermo, M.D. GBMC 6701 N. Charles St. Baltimore, MD 21204													
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendall									

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91 21738

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Florinda EVANGELISTI				2. DATE OF DEATH MONTH 8-8-91 YEAR		3. TIME OF DEATH 9:25 a.m.	
4. SOCIAL SECURITY NUMBER 212-28-5511		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 13, 1913	
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Rossville		9c. COUNTY OF DEATH Baltimore	
RESIDENCE OF DECEDENT							
10a. STATE Md.		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 335 Ida Ave.				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Lougi Piroli				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ines Francisco			
19a. INFORMANT'S NAME (Type/Print) Louisa Axon				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6406 Baldwin Gate Road Baldwin Maryland 21013			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garden of Faith Cemetery 8/10/91 Rossville Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home				22. NAME AND ADDRESS OF FACILITY Connelly Funeral Home 300 Mac Ave. 21221			
23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Renal Failure Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Sepsis Hepatic Dysfunction							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26c. DESCRIBE HOW INJURY OCCURRED	
		26d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		26f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER John Sweeney				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/8/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED DEATH (ITEM 27) (Type, Print) Dr. John Sweeney, MD 9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) AUG 9 1991		32. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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James G. Thompson

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21739			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
AKA Maxine FRANCZKOWIAK				August 9, 1991				4:30 A M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
460 62 8543		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		49 YRS.		Sept. 23, 1941		Texas			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Franklin Square Hospital				Rossville				Baltimore			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Md.		Baltimore		Essex		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
342 Wye Road				21221				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 8				College (1-4 or 5+) Sales Clerk				Department Store			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Ernest York				Doly Stewart							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Lawrence Franczkowiak Husband				342 Wye Road Baltimore, Md. 21221							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Green Mount Cemetery		8/12/91		Baltimore, Md.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
				Bruzdziński Funeral Home PA 1407 Eastern Ave. Baltimore, Md. 21221							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Lung Adenocarcinoma											
DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
DUE TO (OR AS A CONSEQUENCE OF):											
DUE TO (OR AS A CONSEQUENCE OF):											
DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 8 <input type="checkbox"/> Could not be determined						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER							
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				David R. Thaman M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
								D 41846		8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
David Thaman, M.D.				9000 Franklin Square Drive Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
AUG 9 1991				Julia Davidson-Rendell							

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DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21740			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
EDITH ELIZABETH FOGARTY				MONTH DAY YEAR 8 6 91				6:30 P M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
212-44-3499		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		75 YRS.		MONTHS DAYS HOURS MIN. 5-28-16		MARYLAND			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
2616 DAISY AVE.				BALTIMORE				BALTIMORE			
10a. STATE				10b. COUNTY				10c. CITY, TOWN OR LOCATION			
MARYLAND				BALTIMORE				BALTIMORE			
10d. INSIDE CITY LIMITS?				10e. STREET AND NUMBER				10f. ZIP CODE			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				2616 DAISY AVE.				21227			
11. MARITAL STATUS				12. WAS DECEDENT EVER IN U.S. ARMED FORCES?				13. WAS DECEDENT OF HISPANIC ORIGIN?			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
15. DECEDENT'S EDUCATION				16a. DECEDENT'S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5+) 12th NONE				HOMEMAKER				OWN HOME			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
CHARLES HENRY GARDNER				MARY ANN RIENHART							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
CHARLES C. WIDZGA, JR.				3230 TARTARIAN CT. BALTIMORE, MD 21227							
20a. METHOD OF DISPOSITION				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION - City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				NEW CATHEDRAL CEMETERY 8-9				BALTIMORE, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
				SINGLETON FUNERAL HOME 1 SECOND AVE. SW GLEN BURNIE, MD 21061							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → Squamous cell carcinoma											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST metastatic possible from lung											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
Diabetes mellitus Hypertension											
24a. WAS AN AUTOPSY PERFORMED?				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								D21928		8/7/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
LEONEL BARAHONA, MD, 1101 MAIDEN CHOICE LANE, BALTIMORE, MD 21229											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
AUG 9 1991											

Handwritten notes and diagrams, including a large 'X' and various illegible markings.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH91 21741  
REG. NO.

1. DECEASED'S NAME (First, Middle, Last) HARRY ALFRED GILL				2. DATE OF DEATH MONTH DAY YEAR 8 8 91		3. TIME OF DEATH 8:30 a.m.					
4. SOCIAL SECURITY NUMBER 212-07-6756		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 75 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-08-15		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Good Samaritan Hosp.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore				
10a. STATE MD.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				
10e. STREET AND NUMBER 3112 Northway Drive				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11 Yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machinist			16b. KIND OF BUSINESS/INDUSTRY Crown, Cork & Seal				
17. FATHER'S NAME (First, Middle, Last) William Gill				18. MOTHER'S NAME (First, Middle, Maiden Surname) Loula Eisinger							
19a. INFORMANT'S NAME (Type/Print) Ann K. Gill				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3112 Northway Dr., Balto., Md. 21234							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) St. Johns Cemetery		20c. LOCATION — City or Town, State 8-12-91 Long Green, Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Roy H. Cather				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Suspected massive intracranial bleed DUE TO (OR AS A CONSEQUENCE OF): Grade IV Glioblastoma Multiforme Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Hypertension Seizures								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Seizures								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER MD				29c. LICENSE NUMBER D38344		29d. DATE SIGNED (Month, Day, Year) 8/8/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Mary Jo Penburn MD, 5601 Loch Raven Blvd, Balto 21239											
31. DATE FILED (Month, Day, Year) AUG 9 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall									

TABLE 10



91 21742

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CARROLL E. Guy</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1920</b> M	
4. SOCIAL SECURITY NUMBER <b>213-42-2845</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-27-44</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5011 SCHAUB AVE.</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>7TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>H.B. TRUCKING COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH DANIELS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Percille Guy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLORIA GUY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5011 SCHAUB AVE./BALTIMORE, MD 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, mortuary or other place) <b>GARRISON FOREST VA CEM.</b>		DATE		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Francis J. Guy</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Respiratory and cardiac failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Cardiac tamponade</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. history of lung cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>d.</b>						Approximate Interval Between Onset and Death <b>6 days</b> <b>&gt; 6 days</b> <b>1990</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. med. David L. Lewis</i>					
		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR MICHAEL SÖSSENHEIMER 7112 DUCKETS LN #104 ELK RIDGE MD 21227</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.




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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) THELMA A. GREENWICH				2. DATE OF DEATH MONTH DAY YEAR 8 6 91				3. TIME OF DEATH 11:5 A M							
4. SOCIAL SECURITY NUMBER 218-09-1426		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 71 YRS.		7. DATE OF BIRTH (Month, Day, Year) JULY 17, 1920		8. BIRTHPLACE (State or Foreign Country) MARYLAND							
9a. FACILITY NAME (If not institution, give street and number) BON SECOURS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT				10a. STATE MARYLAND				10b. COUNTY							
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO											
10e. STREET AND NUMBER 1718 W. PRATT STREET				10f. ZIP CODE 21223				10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) H/S GRAD		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) TERMINAL OPERATOR		16b. KIND OF BUSINESS/INDUSTRY U.S. GOVERNMENT											
17. FATHER'S NAME (First, Middle, Last) VINCENT DOBER				18. MOTHER'S NAME (First, Middle, Maiden Surname) CLEMENTINA KAVINIS											
19a. INFORMANT'S NAME (Type/Print) DOROTHY ADAMS				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 129 S. FULTON AVENUE, BALTIMORE, MARYLAND 21223											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) MOST HOLY REDEEMER CEMETERY		20c. LOCATION — City or Town, State BALTIMORE											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. ACUTE INFERIOR MYOCARDIAL INFARCTION 90 min DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28c. DESCRIBE HOW INJURY OCCURRED		28d. DATE SIGNED (Month, Day, Year) 8/6/91		28e. LICENSE NUMBER D26339		28f. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ASHTON K. CHOPRA 3455 WILKENS AVE. BALTO. MD 21229					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER  M.D.		29c. DATE FILED (Month, Day, Year) 8/6/91		29d. REGISTRAR'S SIGNATURE 		29e. DATE OF DEATH 8/6/91		29f. REGISTRAR'S SIGNATURE					

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21745

1. DECEDENT'S NAME (First, Middle, Last) <b>SHIRLEY R. HATOFF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 7, 1991</b>		3. TIME OF DEATH M				
4. SOCIAL SECURITY NUMBER <b>220-22-6638</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 31, 1927</b>		8. BIRTHPLACE (State or Foreign Country) <b>Connecticut</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>G.B.M.C.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>				9c. COUNTY OF DEATH <b>Baltimore</b>		
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Baltimore</b>			10c. CITY, TOWN OR LOCATION <b>Parkville</b>			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2803 Glavin Way</b>				10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY <b>State of Maryland Dept. of Education</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Samuel B. Hatoff</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Naomi Rubin</b>						
19a. INFORMANT'S NAME (Type Print) <b>Robert Hatoff</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5115 Pembroke Ave., Baltimore, Md. 21206</b>						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Cemetery 8/10/91</b>		20c. LOCATION — City or Town, State <b>Dorsey, Md.</b>						
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Rd., Balto., Md. 21214</b>						
23. PART I. Enter the disease(s) or conditions that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Metastatic Breast carcinoma</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>3 days</b> <b>3 years</b>										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28i. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> MD				29c. LICENSE NUMBER <b>D33627</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John C. Downs, M.D., 7505 Osler Dr., Suite 504, Towson, Md. 21204</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b> REGISTRAR'S SIGNATURE <i>[Signature]</i>										

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

61 SLIMS



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

91-4481-510				91 21746			
FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE			
1. DECEDECENT'S NAME (First, Middle, Last)				2. DATE OF DEATH		3. TIME OF DEATH	
JAMES HUBBARD III				08 04 1991		12:08 A M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
214-86-9513		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	21 YRS.	2-23-70		Baltimore, Md	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
2112 HERBERT STREET				BALTIMORE city			
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
Maryland				Baltimore		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
2103 N. Pulaski St		21217		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: Black	
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:			
15. DECEDENT'S EDUCATION		16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSINESS/INDUSTRY			
(Specify only highest grade completed)		(Give kind of work done during most of working life. Do NOT use retired.)					
Elementary/Secondary (0-12)		College (1-4 of 5)					
N/A		N/A		Unemployed			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
James Hubbard Jr				Debra Chase			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Mr. James Hubbard				2103 N. Pulaski St. Balto, Md. 21217			
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		(Name of cemetery, crematorium or other place)		DATE			
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Western Star Cem. Md		Balto, Co., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY			
Joseph L. Russ				Joseph L. Russ Funeral Home 2222 W. North Ave. Balto, Md. 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. SHOT GUN WOUND OF HEAD							
DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequently flit conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED?							
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)					
1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH		28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation		08-04-1991		12:01 A		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
2 <input type="checkbox"/> Accident						28d. DESCRIBE NOW INJURY OCCURRED	
3 <input checked="" type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined						SELF - IN-FLICTED WOUND	
4 <input type="checkbox"/> Homicide		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
		HOME		2112 HERBERT STREET			
29a. CERTIFIER (Check only one)							
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
Donald G. Wright MD				OCME		8-4-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
DONALD G. WRIGHT MD DCME 111 N. PENN STREET BALTIMORE, MARYLAND 21202							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
AUG 9 1991				John Davidson-Rodarte			

2015 10

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21747

1. DECEASED'S NAME (First, Middle, Last) <b>LUTHER JAMES HEATH</b>				2. DATE OF DEATH MONTH <b>8</b> - DAY <b>7</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>3:30 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>216-01-7995</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>100</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>SEPT. 9, 1890</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>			
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4219 KENSINGTON ROAD</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8TH GRADE</b> College (1-4 or 5+) <b>MANAGEMENT</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MANAGEMENT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>REAL ESTATE RENTAL</b>					
17. FATHER'S NAME (First, Middle, Last) <b>SAMUEL HEATH</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGARET TURNER</b>							
19a. INFORMANT'S NAME (Type/Print) <b>JEANETTE H. WILSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3931 DANCE MILL ROAD, PHOENIX, MARYLAND 21131</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>8/10</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Neal Colaneri</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229</b>							
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Chronic Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Acute Gastrointestinal Bleeding</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of his knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER <b>D37944</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-7-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>5401 Old Court Rd. Randallstown, MD, 21133</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TABLE 12

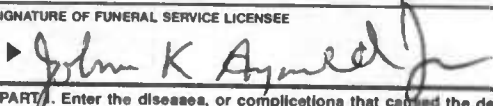
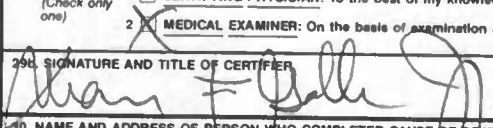
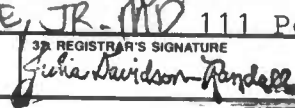
ITEMS: 23, 27 per ME  
G-678 8/22/91 cm  
91-4474-510

91 21748

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James W. Hastings, Sr</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 03 1991</b>		3. TIME OF DEATH <b>3:50 PM</b>			
4. SOCIAL SECURITY NUMBER <b>212-36-5600</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10 31 40</b>			
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>3207 W. Rogers Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			
9c. COUNTY OF DEATH <b>Baltimore City</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Carroll</b>			
10c. CITY, TOWN OR LOCATION <b>Sykesville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5624 Mineral Hill Road</b>			
10f. ZIP CODE <b>21784</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced			
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1960-1963</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10 th</b> College (1-4 or 5+) <b>College</b>				16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Receiving Manager &amp; Inventory Controller-Dub Centre</b>		17. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Wilbur James Hastings</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Louise Brashear</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Michael Hastings</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5624 Mineral Hill Road Sykesville, MD 21784</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Carroll Cremation Serv. 8/7</b>		20c. LOCATION — City or Town, State <b>Hampstead, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MYOCARDIAL INFARCTION DUE TO ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>  Due to (or as a consequence of):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. _____ c. _____ d. _____								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  _____						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 04 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE, JR. MD 111 Penn Street, Baltimore Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1 - FOR  
STATE  
REGISTRAR

91 21749

1. DECEDENT'S NAME (First, Middle, Last) <b>DOROTHY Louise HILL</b>				2. DATE OF DEATH MONTH DAY YEAR <b>July 26 1991</b>		3. TIME OF DEATH <b>11:40p. M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input type="checkbox"/> F <b>X</b>	6. AGE (In yrs. last birthday) <b>72</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>12-13-18</b>		8. BIRTHPLACE (State or Foreign Country)	
9a. FACILITY NAME (If not institution, give street and number) <b>4200 Quinn Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bradbury Heights</b>		9c. COUNTY OF DEATH <b>Prince George's</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Prince Geo Co</b>		10c. CITY, TOWN OR LOCATION <b>Bradbury Heights</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4200 Quinn Street</b>				10f. ZIP CODE <b>20785</b>		10g. CITIZEN OF WHAT COUNTRY?	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <b>instate</b>		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ronald Wade</i> <b>Ronald Wade, Dir</b> <b>8/6/91</b>		22. NAME AND ADDRESS OF FACILITY <b>State Anatomy Board</b> <b>655 W. Baltimore St., Balto., MD 21201</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → Arteriosclerotic cardiovascular disease</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Augusto P. Rodriguez</i>		29c. LICENSE NUMBER <b>D21230</b>		29d. DATE SIGNED (Month, Day, Year) <b>7/27/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Augusto P. Rodriguez, M.D. 5009 Rayburn Ct., Camp Springs, MD 20748</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 8 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GERTRUDE HAMMER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 4, 1991</b>		3. TIME OF DEATH <b>8:20 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-42-2026</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>APR. 14, 1899</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2500 W. BELVEDERE AVE., APT. 909</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2500 W. BELVEDERE AVE., APT. 909</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FASHION DESIGNER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>CLOTHING</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MORRIS GOLDSTEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. RUTHELLEN SCHLOSS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4406 DITTMAR RD. ARLINGTON, VA 22207</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE HEBREW 8/6/91</b>		20c. LOCATION — City or Town, State <b>REISTERSTOWN, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ellenue Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>METASTATIC CARCINOMA</b> <b>Due to (or as a consequence of):</b> <b>Primary unknown</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Asymptomatic</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Rodriguez</i>				29c. LICENSE NUMBER <b>016961</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>B. Cochran, 6506 PARK HEIGHTS AVE, BALTO. MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MIRIAM HYMAN				2. DATE OF DEATH MONTH DAY YEAR 8 1 91		3. TIME OF DEATH 2 5 P M	
4. SOCIAL SECURITY NUMBER 220-14-8254		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 29, 1922	
8. BIRTHPLACE (State or Foreign Country) MARYLAND				9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND			
10b. COUNTY BALTIMORE				10c. CITY, TOWN OR LOCATION BALTIMORE			
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 7609 SEVEN MILE LANE			
10f. ZIP CODE 21208				10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE		16b. KIND OF BUSINESS/INDUSTRY AT HOME			
17. FATHER'S NAME (First, Middle, Last) JOSEPH POMERANTZ				18. MOTHER'S NAME (First, Middle, Maiden Surname) IDA SCHMULOVITZ			
19a. INFORMANT'S NAME (Type/Print) MRS. SUSAN BLAVATT				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3401 NANCY ELLEN WAY OWINGS MILLS, MD 21117			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BNAT ISRAEL 8/4/91		20c. LOCATION — City or Town, State BALTIMORE, MD		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>		22. NAME AND ADDRESS OF FACILITY SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. RESPIRATORY FAILURE. Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { b. ENDOMETRIAL CARCINOMA. c. PULMONARY EMBOLISM. d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Karlofation M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 08.01.91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KARLOFATION UNION MEMORIAL HOSPITAL BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 4, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21752

1. DECEDENT'S NAME (First, Middle, Last) <b>PIERCE L. HUNTER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:40 A.M.</b>							
4. SOCIAL SECURITY NUMBER <b>248-24-5427</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-14-1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>University of Maryland</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH					
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1800 Hollins St.</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Construction Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Building Industry</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Pierce Hunter</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Pearlie Blakely</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Mr. and Mrs. Charlie Bryson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5234 Fredcrest Rd. Balto., Md. 21229</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star Cemetery</b>		20c. LOCATION — City or Town, State <b>Catonsville Md.</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Derrick C. Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto., Md. 15</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Myocardial Infarction leading to Cardiac Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Liver Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Trevor A. Litchner M.D.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Trevor A. Litchner, University Hospital, 22 South Green St. BALTO. MD</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21753

1. DECEDENT'S NAME (First, Middle, Last) <b>HILDE ISLORITZ (HILDEGARD ISLOVITZ)</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>3</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:20 A M</b>				
4. SOCIAL SECURITY NUMBER <b>045-12-1035</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>05/19/1903</b>		8. BIRTHPLACE (State or Foreign Country) <b>GERMANY</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Lorisa Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>			9c. COUNTY OF DEATH <b>Howard</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Columbia</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6336 CEDAR LANE</b>				10f. ZIP CODE <b>21044</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>			16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MEYER BLUMENTHAL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOHANNA WOLFE</b>						
19a. INFORMANT'S NAME (Type/Print) <b>MRS. HELEN WERMUTH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>10168 PLACID LAKE CT. COLUMBIA, MD 21044</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>UNITY CLUB</b>		DATE <b>8/5/91</b>		20c. LOCATION — City or Town, State <b>FAIRFIELD, CT</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jay P. Russell</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Congestive Heart Failure</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Obstructive Pulmonary Disease</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jay P. Russell MD</i>					29c. LICENSE NUMBER <b>B2133165</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/3/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JAY P. RUSSELL MD 11055 Little Potomac Parkway Columbia MD</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						

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91 21754

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EUGENE E. JONES Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 06 1991</b>		3. TIME OF DEATH <b>10:20 p M</b>	
4. SOCIAL SECURITY NUMBER <b>213-86-8165</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>19</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-14-71</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>HALLWAY-130 NORTH AISQUITH ST.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>none</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>none</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>200 N. Aisquith Street Apt. 11J</b>	
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>NEGROID</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>11th grade</b> College (1-4 or 5+) <b>none</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Eugene E. Jones, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lila Watson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lila Stewart</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1114 Webb Court/Balto, Maryland 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery 8-13-91</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Multiple Gunshot Wounds</b>				Approximate Interval Between Onset and Death	
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b>HALLWAY-HIGHRISE</b>					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>08 06 1991</b>		28b. TIME OF INJURY <b>11:08 P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HALLWAY-130 N. AISQUITH ST.</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>BALTIMORE CITY</b>			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Harold Lake MD</i>							
29c. LICENSE NUMBER <b>OCME</b>				29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Harold Lake MD</i> <b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>Lila Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DIVISION OF VITAL RECORDS, P.O. BOX 13146.

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DHMH-16 Rev 1/89

21 1132

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21756

1. DECEDENT'S NAME (First, Middle, Last) <b>STANLEY KRAWITZ</b> aka: <b>RAY</b>			2. DATE OF DEATH MONTH DAY YEAR <b>August 2 1991</b>		3. TIME OF DEATH <b>3:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>68</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 9, 1922</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>124 STRONGWOOD RD.</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>REISTERSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT						
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>REISTERSTOWN</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>124 STRONGWOOD RD.</b>			10f. ZIP CODE <b>21136</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>SALESMAN</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SALESMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL</b>		
17. FATHER'S NAME (First, Middle, Last) <b>MAX KRAWITZ</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LENA LEWIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. FLORENCE POLAN</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7219 PARK HEIGHTS AVE., APT. 101 BALTO., MD 21208</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARLINGTON (CHIZUK AMUNO) 8/4/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Janet Lewis</i>			22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>acute myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>9m-11a</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>none</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stanley Z. Gelfand</i> Deputy Medical Examiner		29c. LICENSE NUMBER <b>01085</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 3, 1991</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Stanley Z. Gelfand, M.D. 1 E. Chase St 21202</b>						
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>				

01 51356

ITEM:4 per FH  
G-678 8/14/91 cm

91 21757

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>James McCoy</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH <b>950 P M</b>					
4. <b>250-03-0766</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month / Day / Year) <b>01/27/13</b>		6. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>VA at Loch Raven Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore MD</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4320 CLAREWAY STREET</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>DISABLED</b>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>CHARLIE MCCOY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HATTIE</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MABLE MANNS SEXTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15627 VAN NOSTRAND ST./RIVERSIDE, CA 92508</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Coronary Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Atrial Fibrillation</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> 1. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> 2. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael S. S. M.D.</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Michael S. S. M.D. 4302 Robert Ave. 22 S. Greene St. Balt Md</b>											
31. DATE FILED (Month, Day, Year) <b>8/6/91 AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>						21201			

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91 21758

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Baby Shavon L. Miller</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 6, 1991</b>		3. TIME OF DEATH HOURS MINUTES <b>5:41 P M</b>	
4. SOCIAL SECURITY NUMBER <b>NA</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>3</b>		7. DATE OF BIRTH (Month, Day, Year) <b>8-3-91</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2419 DENISON STREET</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>NA</b> College (1-4 or 5+) <b>Child</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Child</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Child</b>			
17. FATHER'S NAME (First, Middle, Last) <b>VICTOR MILLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIAN LEWIS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LILLIAN LEWIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2419 DENISON ST./BALTIMORE, MD 21216</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>KING MEM. PARK Cem.</b>		DATE		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRAIN Death</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Hypoxia</b> b. <b>Pulmonary Hypertension</b> c. <b>Pulmonary Hypertension</b> d. <b>Pulmonary Hypertension</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <b>3 Days</b> <b>3 Days</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>36426</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DIANA LYN DAVIDSON - JOHNS HOPKINS HOSPITAL, Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Bureau of Vital Records. **IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.**

01 51758

91 21759

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Myers Rodney Tyrone</b>				2. DATE OF DEATH MONTH <b>9</b> DAY <b>4</b> YEAR <b>91</b>		3. TIME OF DEATH <b>8:05</b> M	
4. SOCIAL SECURITY NUMBER <b>216-62-4774</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-23-55</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>420 E. NORTH AVENUE</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8th Grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM MYERS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BLANCHE DODD</b>			
19a. INFORMANT'S NAME (Type/Print) <b>BLANCHE BROWN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1001 TIFFANY CT./BALTIMORE, MD 21201</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>KING MEMORIAL PARK Cem.</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bladys W...</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic Shock</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>HIV / AIDS : Severe Immuno suppression</b> <b>Severe Anemia</b> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Myr Blakeslee DO Resident</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/4/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Marsha Y Blakeslee Union Mem. Hosp Balto, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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**IMPORTANT:** If Item 28 is marked or Item 23 shows any injury, or other traumatic event, the medical exam

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21760

Hilwert Knotts-Mathews										REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>(HILWERT MAE MATTHEWS)</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>04</b> YEAR <b>91</b>		3. TIME OF DEATH <b>06:25P M</b>							
4. SOCIAL SECURITY NUMBER <b>212-34-4108</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/15/1937</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>						
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>						
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>1701 E. NORTH AVE. # 314</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>STATE OF MD/FOOD SERV.</b>							
17. FATHER'S NAME (First, Middle, Last) <b>DANIEL VAUGHAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNIE HUBBARD</b>									
19a. INFORMANT'S NAME (Type/Print) <b>RUTH ALLEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>143 S. KOSSUTH STREET/BALTIMORE, MD 21229</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>BALTIMORE CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>CML M BLAST CRISIS</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide 4 <input type="checkbox"/> Other		27. DATE OF INJURY (Month, Day, Year) _____		28a. TIME OF INJURY <b>M</b>		28b. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. DESCRIBE NOW INJURY OCCURRED _____			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. C. H.</i>		29c. LICENSE NUMBER <b>027730</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GARY CORNER, MD. 6565 N. CHAS. ST. BALTO MD 21204</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Lisa Davidson-Rendell</i>									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21761

1. DECEDENT'S NAME (First, Middle, Last) George B. MALONE				2. DATE OF DEATH August 8, 1991				3. TIME OF DEATH 4:22 A M			
4. SOCIAL SECURITY NUMBER 072-12-3356		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) 8-15-1922		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore				9c. COUNTY OF DEATH Baltimore			
10a. STATE Md.		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 4 Raylon Drive. Apt. F.				10f. ZIP CODE 21236		10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WWII		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) 2yrs.				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Radio Dispatcher				16b. KIND OF BUSINESS/INDUSTRY City Of Baltimore			
17. FATHER'S NAME (First, Middle, Last) George B. Malone				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marion Hare							
19a. INFORMANT'S NAME (Type/Print) Mrs. Rebecca C. Malone				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Raylon Dr. #F Balto., Md. 21236							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Oak Lawn Cemetery				DATE		20c. LOCATION — City or Town, State Balto., Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gay S. Skismon</i>				22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 Harford Rd. Balto., Md. 21234							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter this mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → s. Ventricular Fibrillation DUE TO (OR AS A CONSEQUENCE OF): b. Anterior Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): c. Anoxic Encephalopathy DUE TO (OR AS A CONSEQUENCE OF): d. Diabetes Mellitus Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Stephen G. Smaldore</i> 8/8/91						29c. LICENSE NUMBER N/A		29d. DATE SIGNED (Month, Day, Year) August 8, 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Stephen G. Smaldore, M.D. 9000 Franklin Square Drive Baltimore, MD 21237											
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE <i>Johie Davidson-Randall</i>							

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


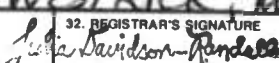
TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21762

1. DECEDENT'S NAME (First, Middle, Last) RICHARD ALLEN MILBY, JR.				2. DATE OF DEATH MONTH 8- DAY 6- YEAR 91		3. TIME OF DEATH 3:35 P M							
4. SOCIAL SECURITY NUMBER 214-66-1758		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 1-4-55		8. BIRTHPLACE (State or Foreign Country) Baltimore					
9a. FACILITY NAME (If not institution, give street and number) 8041 GREENLEAF TERR APT. 21				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE			9c. COUNTY OF DEATH ANNE ARUNDEL						
10a. STATE MD		10b. COUNTY -----		10c. CITY, TOWN OR LOCATION BALTIMORE			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						
10e. STREET AND NUMBER 813 SOUTH MILTON AVE.				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? U.S.A.							
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE						
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) NONE				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SALES			15b. KIND OF BUSINESS/INDUSTRY SELF EMPLOYED						
17. FATHER'S NAME (First, Middle, Last) RICHARD ALLEN MILBY, SR.				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY GLORIA MILBY									
19a. INFORMANT'S NAME (Type/Print) MARY GLORIA MILBY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 8041 GREENLEAF TERR. APT. 21 GLEN BURNIE, MD 21261									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) METRO CREMATORY		DATE		20c. LOCATION — City or Town, State Baltimore, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CMV Pneumonia, Colitis, Rhinitis DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. AIDS DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Samuel J. Westrick MD				29c. LICENSE NUMBER 128625		29d. DATE SIGNED (Month, Day, Year) 8-7/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) SAMUEL J. WESTRICK, MD 3100 St. Paul St, Baltimore MD 21218													
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE 									

(The following table shows the results of the survey conducted in the year 1912)

1/11 - 1912  
The following table shows the results of the survey conducted in the year 1912

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21763

1. DECEDENT'S NAME (First, Middle, Last) <b>Rose Miller (ROSE E. MILLER)</b>						2. DATE OF DEATH MONTH DAY YEAR <b>8-06-91</b>		3. TIME OF DEATH <b>8:15 PM</b>		
4. SOCIAL SECURITY NUMBER <b>213-12-3935</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>87</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>7-12-04</b>		8. BIRTHPLACE (State or Foreign Country) <b>CANADA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Baltimore County General Hosp.</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Randallstown</b>			9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>18 WARREN PARK DR., APT. B-4</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>			15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BEAUTICIAN</b>			15b. KIND OF BUSINESS/INDUSTRY <b>COSMETOLOGY</b>				
17. FATHER'S NAME (First, Middle, Last) <b>ALEX MILLER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH GOODMAN</b>						
19a. INFORMANT'S NAME (Type/Print) <b>MR. ELLIOTT MILLER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7202 ROCKLAND HILLS DR., APT. 505 BALTO., MD 21209</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other facility) <b>MIKRO KODESH-BETH ISRAEL 8/8/91</b>			DATE <b>8/8/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 reisterstown rd. BALTO., MD 21215</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>s. End Stage Cardiomypopathy</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.									Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. PLACE OF INJURY — At home, farm, street, factory, office, building, etc. (Specify)		29c. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29c. SIGNATURE AND TITLE OF CERTIFIER 				29d. LICENSE NUMBER <b>D37949</b>		29e. DATE SIGNED (Month, Day, Year) <b>8-6-91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Type, Print) <b>5401 Old Court Rd, Randallstown, MD, 21133</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>			32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21764			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>MARGARETTE P. MITCHELL</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>5</b> YEAR <b>91</b>				3. TIME OF DEATH <b>M</b>			
4. SOCIAL SECURITY NUMBER <b>244-52-8798</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-17-36</b>		8. BIRTHPLACE (State or Foreign Country) <b>Raleigh, N.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>1411 Druid Hill Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore, Maryland</b>				9c. COUNTY OF DEATH			
10a. STATE <b>MD</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore, Maryland</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1411 Druid Hill Avenue</b>				10f. ZIP CODE <b>21217</b>			
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES			
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>X</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY				17. FATHER'S NAME (First, Middle, Last) <b>Charlie Hodges</b>			
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lula Bell Chapman</b>				19a. INFORMANT'S NAME (Type/Print) <b>Charlmye Alston</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2867 W. Mulberry St. Baltom MD 21217</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem. Pk. Balto, MD</b>				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James G. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>JAMES A. MORTON &amp; SONS F.H. 1701 LARRONS Street F. Balto, MD</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> a. DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. <b>Coronary atherosclerosis</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <b>1 Day</b> <b>3 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Polyarthritis</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>James G. Morton M.D.</b>				29c. LICENSE NUMBER <b>D13064</b>			
29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BOYALD S. POTOTSKY M.D. 821 N. EUTAW ST #202 BALTO MD 21201</b>				31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>			
32. REGISTRAR'S SIGNATURE <b>John S. ...</b>											

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91 21765

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HORDGE, NORMAN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>218-10-3030</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>103</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-08-88</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Chattanooga, TN</b>				9. FACILITY NAME (If not institution, give street and number) <b>Church Hospital</b>		10. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
11. RESIDENCE OF DECEDENT <b>Chattanooga, TN</b>				12. STATE <b>MD</b>		13. COUNTY <b>Baltimore</b>	
14. CITY, TOWN OR LOCATION <b>Baltimore, MD</b>				15. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		16. STREET AND NUMBER <b>601 Wynade Avenue</b>	
17. ZIP CODE <b>21218</b>				18. CITIZEN OF WHAT COUNTRY? <b>USA</b>		19. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
20. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				21. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
22. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				23. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>			
24. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>				25. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>			
26. FATHER'S NAME (First, Middle, Last) <b>Jack Hordge</b>				27. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Catherine Hordge</b>			
28. INFORMANT'S NAME (Type/Print) <b>Rev. Richard Tabron</b>				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1353 Winston Avenue, Balto, MD 21239</b>			
30. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				31. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery</b>			
32. LOCATION — City or Town, State <b>Balto, MD.</b>				33. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>			
34. NAME AND ADDRESS OF FACILITY <b>JAMES A. MORTON &amp; SONS F. H., 1701 Laurens St. Balto, MD 21217</b>				35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Severe Renal Failure</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Sepsis</b> <b>UTI</b> <b>CLL</b>			
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				37. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
38. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				39. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
40. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				41. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
42. DATE OF INJURY (Month, Day, Year) <b>08/06/91</b>				43. TIME OF INJURY <b>M</b>			
44. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				45. DESCRIBE HOW INJURY OCCURRED			
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				47. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
48. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				49. SIGNATURE AND TITLE OF CERTIFIER <b>W. Navarro</b> <b>Med. Specialist</b>			
50. LICENSE NUMBER <b>D 40 356</b>				51. DATE SIGNED (Month, Day, Year) <b>08/06/91</b>			
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>W. Navarro</b> <b>100 N. Broadway Balto. MD. 21231</b>				53. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>			
54. REGISTRAR'S SIGNATURE <b>John Davidson</b>				55. REGISTRAR'S TITLE <b>Registrar</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 21766

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ELEANORA C. O'DONOVAN				2. DATE OF DEATH MONTH 8 DAY 5 YEAR 91		3. TIME OF DEATH 7:55 P. M.	
4. SOCIAL SECURITY NUMBER 220-32-3652		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 83 YRS.	7. DATE OF BIRTH (Month, Day, Year) 1-11-08		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) KESWICK 700 W. 40th. STREET				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE		9c. COUNTY OF DEATH	
10a. STATE MARYLAND				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE CITY	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER 700 WEST 40th STREET		10f. ZIP CODE 21211	
10g. CITIZEN OF WHAT COUNTRY? U.S.A.				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (13-16 or 17+) 4	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOUSEWIFE				16b. KIND OF BUSINESS/INDUSTRY OWN HOME		17. FATHER'S NAME (First, Middle, Last) JOHN CROSSAN COOPER	
18. MOTHER'S NAME (First, Middle, Maiden Surname) LOUISA JENKINS				19a. INFORMANT'S NAME (Type/Print) DR. CHARLES O'DONOVAN III		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 600 GREENWOOD RD., TOWSON, MD. 21204	
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) NEW CATHEDRAL CEM. 8-19-91		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE R. H. Rutt				22. NAME AND ADDRESS OF FACILITY HENRY W. JENKINS AND SONS 4905 YORK RD. BALTO. MD. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → ACUTE MYOCARDIAL INFARCTION							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. A.S.C.V.D.							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CHRONIC OBSTRUCTIVE LUNG DISEASE AND ASTHMATIC BRONCHITIS							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, tectory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Charles O'Donovan III M.D.				29c. LICENSE NUMBER D 12399		29d. DATE SIGNED (Month, Day, Year) AUGUST 5, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) CHARLES O'DONOVAN III M.D. 700 W. 40th. STREET, BALTO. MD. 21211							
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO BE COMPLETED BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO BE COMPLETED BY FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


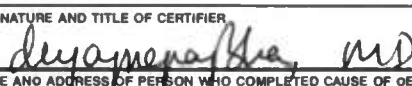

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

5 MED

1. DECEDENT'S NAME (First, Middle, Last) <b>Ethel Anna Olszewski</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>09</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0340</b>	
4. SOCIAL SECURITY NUMBER <b>212-28-4926</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-16-17</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>The Good Samaritan Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore, MD.</b>		9c. COUNTY OF DEATH <b>MD</b>	
10a. STATE <b>Md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3414 Esther Place</b>				10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>own home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Louis F. Andrathy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelia Shenner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>John M. Olszewski</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7907 Montrose Avenue 21237</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Moran-Ashton Funeral Home</b> <b>3000 E. Baltimore Street 21224</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis 2° to Gangrenous (R) foot</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;"> <b>Peripheral Vascular Disease.</b>  <b>Endstage Renal Disease.</b>  <b>Chronic Hypertension.</b> </div> <div style="width: 35%;">           Approximate Interval Between Onset and Death  <b>ONE MONTH</b> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Seizure disorder.</b> <b>Recurrent deep venous thrombosis</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BEN A. DWAMENA MD</b> <b>GOOD SAMARITAN HOSPITAL OF BALTO, 5601 LOCK RAVEN BLVD, BALTO, MD 21235</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 24 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Raymond W Popp</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:31P</b> M	
4. SOCIAL SECURITY NUMBER <b>214-05-3930</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-31-1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital At Easton</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Easton</b>	
9c. COUNTY OF DEATH <b>Talbot</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Queen Anne</b>	
10c. CITY, TOWN OR LOCATION <b>Grasonville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>Box 93, Chester River Beach Rd.</b>	
10f. ZIP CODE <b>21638</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12 Yrs.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Production Controller</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Martin Marietta</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Popp</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Seibert</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen M. Popp</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Box 93, Chester River Beach Rd., Grasonville, Md. 21638</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery 8-12-91</b>		20c. LOCATION — City or Town, State <b>Rosedale, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Roy H. Cather</b> <i>Roy H. Cather</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Suspected Myocardial infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Diabetes mellitus</b> <b>Atherosclerosis</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval Between Onset and Death							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Amelio R. Brown</i>				29c. LICENSE NUMBER <b>D27409</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-7-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <b>Dutchman's Lane Easton, Md. 21601</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21769

1. DECEDENT'S NAME (First, Middle, Last) <b>CLYDE L. PETERSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 2, 1991</b>				3. TIME OF DEATH <b>M</b>					
4. SOCIAL SECURITY NUMBER <b>090 07 5022</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 23, 1908</b>		8. BIRTHPLACE (State or Foreign Country) <b>TENNESSEE</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>FRANCIS SCOTT KEY</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH					
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4911 EAST FEDERAL STREET</b>				10f. ZIP CODE <b>21205</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8 YRS.</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SELF-EMP OWNER</b>		15b. KIND OF BUSINESS/INDUSTRY <b>GROCERY STORE</b>									
17. FATHER'S NAME (First, Middle, Last) <b>GROVER L. PETERSON</b>				18. MOTHER'S NAME (First, Middle, Surname) <b>MAUD PETERSON</b>									
19a. INFORMANT'S NAME (Type/Print) <b>FAMILY RECORDS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ABOVE</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>FEDERAL HILL CEM.</b>		DATE <b>8-2</b>		20c. LOCATION — City or Town, State <b>BALTO., MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>[Signature]</b>		22. NAME AND ADDRESS OF FACILITY <b>BRANCH OF MEMORIES 8800 HARFORD ROAD-PARKVILLE</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>LUNG CANCER</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>TOBACCO USE</b> DUE TO (OR AS A CONSEQUENCE OF):   DUE TO (OR AS A CONSEQUENCE OF):   Approximate Interval Between Onset and Death <b>6 MONTHS</b> <b>60 YEARS</b>													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>DR. ROSS ABRAMS</b>		29c. LICENSE NUMBER <b>D20291</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUG. 5, 1991</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. ROSS ABRAMS</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

08913 17

Handwritten notes and markings, including a signature and some illegible text.



91 21770

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SOPHIE S. PARR</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>06</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1:30 P M</b>			
4. SOCIAL SECURITY NUMBER <b>216-46-5587</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>32</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 11, 1959</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>		
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>GLYNDON</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER <b>13800 LONGNECKER ROAD</b>				10f. ZIP CODE <b>21071</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ARTIST</b>		16b. KIND OF BUSINESS/INDUSTRY <b>ART</b>					
17. FATHER'S NAME (First, Middle, Last) <b>THOMAS D.R. PARR</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JENEPHER LEE BURTON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>THOMAS D.R. PARR</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>13800 LONGNECKER ROAD. GLYNDON, MD. 21071</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ST. JOHNS CHURCH CEMETERY</b>		20c. LOCATION — City or Town, State <b>GLYNDON, MD. 21071</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Eliam M. Perkins</i>				22. NAME AND ADDRESS OF FACILITY <b>4905 YORK ROAD 21212 HENRY W. JENKINS AND SONS. BALTIMORE, MD.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute renal failure</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>VENOOCCLUSIVE DISEASE OF THE LIVER</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>CHEMOTHERAPY TOXICITY (busulfan, cyclophosphamide)</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>ACUTE LYMPHOBLASTIC LEUKEMIA</b> DUE TO (OR AS A CONSEQUENCE OF): d.  Approximate Interval Between Onset and Death <b>15 days</b> <b>17 days</b> <b>17 days</b> <b>3 years</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ephraim Fuchs M.D. Senior Clinical Fellow</i>						29c. LICENSE NUMBER <b>D37208 (md.)</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ephraim Fuchs MD Johns Hopkins Oncology Center 600 N. Wolfe St. Balt. Md. 21205</b>									
31. DATE FILED (Month, Day, Year) <b>8 AUG 9 1991</b>			32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE REGISTRAR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be retained by the funeral director. Page 4 should be retained by the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91-21771

1. DECEDENT'S NAME (First, Middle, Last) JOHN QUARLES				2. DATE OF DEATH MONTH 08 DAY 03 YEAR 91 TIME OF DEATH 02:31 PM											
4. SOCIAL SECURITY NUMBER 216-44-5530		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 7/26/47		8. BIRTHPLACE (State or Foreign Country) Balto., MD.							
9a. FACILITY NAME (If not institution, give street and number) NORTH ARUNDEL HOSPITAL ASSOCIATION				9b. CITY, TOWN OR LOCATION OF DEATH GLEN BURNIE				9c. COUNTY OF DEATH A.A. COUNTY							
10a. STATE Balto., MD		10b. COUNTY Anne Arundel Cty		10c. CITY, TOWN OR LOCATION Glen Burnie, Maryland				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 7776 B & A Blvd., Glen Burnie, MD				10f. ZIP CODE 21060		10g. CITIZEN OF WHAT COUNTRY? United States									
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: X		14. RACE — American Indian, Black, White, etc. Specify: Black									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Carpenter				16b. KIND OF BUSINESS/INDUSTRY Industrial									
17. FATHER'S NAME (First, Middle, Last) Jessie Quarles				18. MOTHER'S NAME (First, Middle, Maiden Surname) Margeline Sewell											
19a. INFORMANT'S NAME (Type/Print) Robert Quarles				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7776 B&A Blvd., Baltimore, MD 21060											
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MacNabb Crematory		20c. LOCATION — City or Town, State 8/10/91 Balto., MD.											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James G. Morton				22. NAME AND ADDRESS OF FACILITY JAMES A. MORTON & SONS F. H. 1701 LAURENS STREET, BALTO., MD											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Dilated Cardiomyopathy b. Coronary artery disease c. d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								24. Approximate interval between Onset and Death 2 11							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										29b. SIGNATURE AND TITLE OF CERTIFIER Kevin J. Doyle M.D.		29c. LICENSE NUMBER D 31122		29d. DATE SIGNED (Month, Day, Year) 8/3/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) KEVIN J. DOYLE, M.D./203 HOSPITAL DRIVE, #206/GLEN BURNIE, MARYLAND 21061										31. DATE FILED (Month, Day, Year) AUG 9 1991		32. REGISTRAR'S SIGNATURE John Davidson			

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91 21772

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) ROSALIE G. ROWE				2. DATE OF DEATH MONTH DAY YEAR AUGUST 7, 1991		3. TIME OF DEATH 3:55 pm M	
4. SOCIAL SECURITY NUMBER 216-36-7072		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 78 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 17, 1912	
9a. FACILITY NAME (If not institution, give street and number) FREDERICK VILLA NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION CATONSVILLE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 333 GREENLOW RD.				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY ST. MARK CHURCH			
17. FATHER'S NAME (First, Middle, Last) HOWARD GRIMES				18. MOTHER'S NAME (First, Middle, Maiden Surname) ROSE FUSTING			
19a. INFORMANT'S NAME (Type/Print) LINDA ROWE (DAUGHTER-IN-LAW)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 333 GREENLOW ROAD, CATONSVILLE, MARYLAND 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE NATIONAL CEMETERY 8/9/91		20c. LOCATION — City or Town, State WOODLAWN, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Carcinomatosis</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. _____ DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① Alzheimer's</i> <i>② NO CPR</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Goeyoso, M.D.</i>				29c. LICENSE NUMBER <i>12-19528</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/8/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>LEMO M. GAYOSO</i> <i>5411 Old Frederick Road</i> <i>Balto. Md. 21229</i>							
31. DATE FILED (Month, Day, Year) AUG 9 1991		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

4

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ITEM:4 per FG  
G-678 8/30/91 cm

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21773

1. DECEDENT'S NAME (First, Middle, Last) HILDA A. RUEHLING				2. DATE OF DEATH MONTH DAY YEAR AUGUST 9, 1991		3. TIME OF DEATH 12:05 A. M			
4. SOCIAL SECURITY NUMBER 214-22-2393		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) April 19, 1914		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) MERIDAN NURSING HOME				9b. CITY, TOWN OR LOCATION OF DEATH CATONSVILLE			9c. COUNTY OF DEATH BALTIMORE		
10a. STATE MARYLAND		10b. COUNTY HOWARD		10c. CITY, TOWN OR LOCATION ELLICOTT CITY			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 3410 WALNUT DRIVE				10f. ZIP CODE 21043		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SECRETARY		16b. KIND OF BUSINESS/INDUSTRY W. R. GRACE CO.			
17. FATHER'S NAME (First, Middle, Last) HERMAN ALKER				18. MOTHER'S NAME (First, Middle, Maiden Surname) ERNESTINA THOM					
19a. INFORMANT'S NAME (Type Print) WILLIAM F. ALKER (NEPHEW)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 312 MARDO AVENUE, LANSLOWNE, MARYLAND 21227					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) LOUDON PARK CEMETERY		DATE 8/12/91		20c. LOCATION — City or Town, State BALTIMORE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. Russell C. Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Metastatic colon adenocarcinoma</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan Stahl, M.D.</i>				29c. LICENSE NUMBER D13998		29d. DATE SIGNED (Month, Day, Year) 8/9/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ALAN STAHL M.D. 4801 DORSEY HALL DR. #201 ELLICOTT CITY MD 21043									
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE <i>Lelia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0060  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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11/11/11



ITEMS:23,27 per ME  
G-678 8/22/91 cm  
91-4470-015

91 21774

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Raymond Carl Rochester, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 03 1991</b>		3. TIME OF DEATH <b>8:49 A M</b>	
4. SOCIAL SECURITY NUMBER <b>n/a</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS <b>1 19</b>		7. DATE OF BIRTH (Month, Day, Year) <b>June 15, 1991</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>188 Hollingsworth Manor</b>			
9b. CITY, TOWN OR LOCATION OF DEATH <b>Elkton</b>				9c. COUNTY OF DEATH <b>Cecil</b>			
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Cecil</b>		10c. CITY, TOWN OR LOCATION <b>Elkton</b>	
10d. INSIDE CITY LIMITS? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>				10e. STREET AND NUMBER <b>188 Hollingsworth Manor</b>			
10f. ZIP CODE <b>21921</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <b>1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) n/a</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>n/a</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Raymond Carl Rochester, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Cindy L. McCreary</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Cindy L. McCreary</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>188 Hollingsworth Manor Elkton, MD 21921</b>			
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Elkton Cemetery 8-7 1991</b>		20c. LOCATION — City or Town, State <b>Elkton, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph E. Hicks</i>				22. NAME AND ADDRESS OF FACILITY <b>Hicks Home for Funerals, P.A. Bow and Stockton Streets Elkton, MD 21921</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>BRONCHOPNEUMONIA</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. MANNER OF DEATH <b>1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b> <b>2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined</b> <b>3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sharon F. Galt</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 04 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIB, JR. MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Linda Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWARD KING RAKER</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>91</b>		3. TIME OF DEATH <b>08:40 AM</b>	
4. SOCIAL SECURITY NUMBER <b>578-01-2399</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-10-14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>PENNSYLVANIA</b>				9. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>				11. COUNTY OF DEATH <b>A.A. COUNTY</b>			
12a. STATE <b>MARYLAND</b>		12b. COUNTY <b>ANNE ARUNDEL</b>		12c. CITY, TOWN OR LOCATION <b>PASADENA</b>		12d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
13. STREET AND NUMBER <b>1243 LORENE DRIVE</b>				14. ZIP CODE <b>21122</b>		15. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
20. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>6 MNTHS.</b>		21. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MACHINE OPERATOR</b>		22. KIND OF BUSINESS/INDUSTRY <b>SOAP MANUFACTURER</b>			
23. FATHER'S NAME (First, Middle, Last) <b>HARRY RAKER</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LORETTA MARY KING</b>			
25. INFORMANT'S NAME (Type/Print) <b>EDWARD M. RAKER</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1346 AVA RD. SEVERN, MD 21144</b>			
27. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>STONE VALLEY CEMETERY</b>		29. DATE <b>08/08/91</b>		30. LOCATION — City or Town, State <b>LOWER MAHONEY TOWNSHIP, PA.</b>	
31. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Hopkins</i>				32. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>			
23. PART I. Enter the diseases, or complications, met caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF LUNG</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CIRRHOSIS OF THE LIVER</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28. DATE OF INJURY (Month, Day, Year) <b>08/08/91</b>	
29. TIME OF INJURY <b>08:40 AM</b>		30. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		31. DESCRIBE HOW INJURY OCCURRED			
32. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				33. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
34. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
35. SIGNATURE AND TITLE OF CERTIFIER <i>Salvacion A. Dupaya</i>				36. LICENSE NUMBER <b>038912</b>		37. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
38. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SALVACION A. DUPAYA, M.D./301 HOSPITAL DRIVE/GLEN BURNIE, MARYLAND 21061</b>							
39. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				40. REGISTRAR'S SIGNATURE <i>J. Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Handwritten signature or text

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

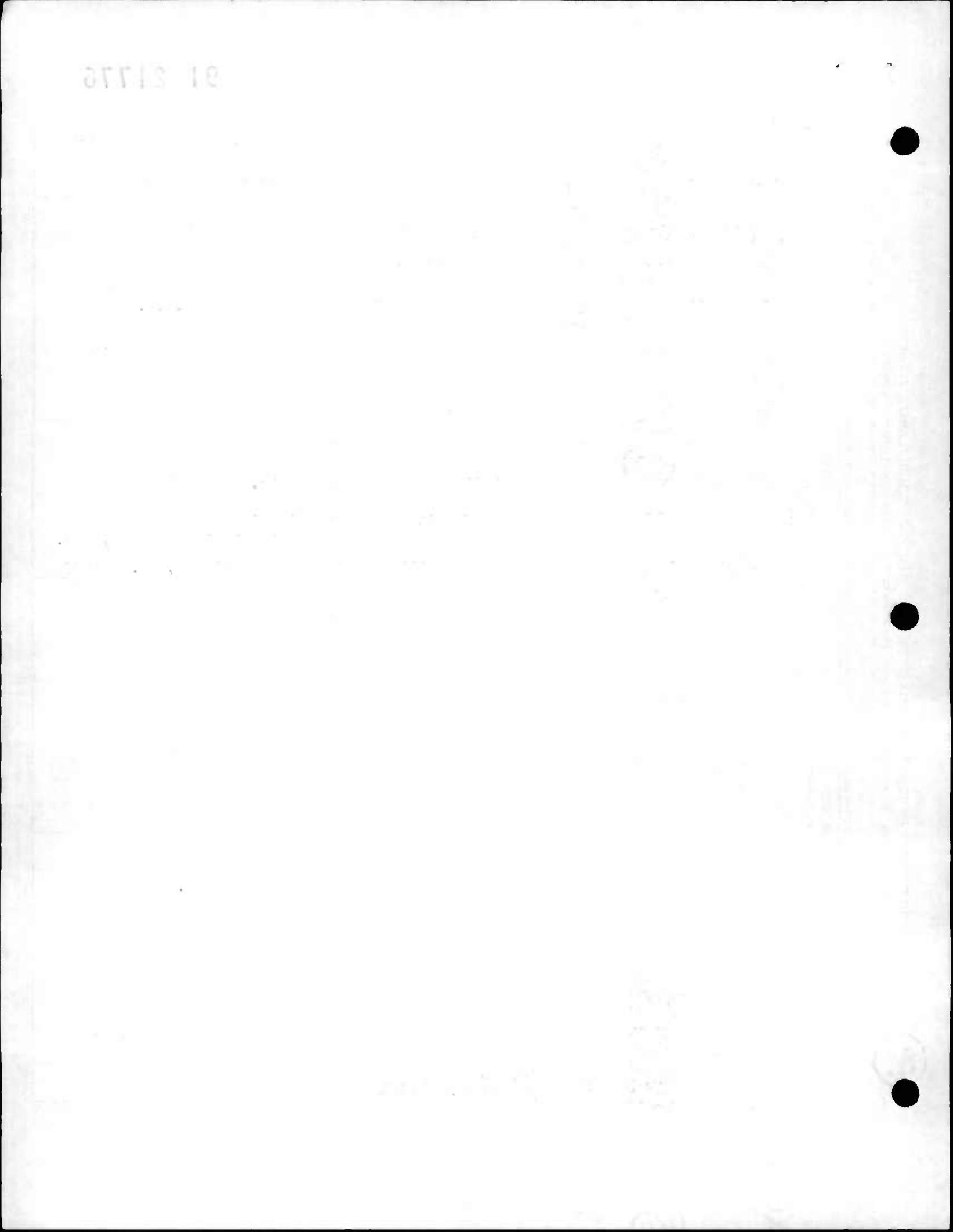
1. DECEDENT'S NAME (First, Middle, Last) Frances Marian RAY				2. DATE OF DEATH MONTH DAY YEAR 08/07/91		3. TIME OF DEATH 7:30 P M	
4. SOCIAL SECURITY NUMBER 214-50-6522		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/23/18	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) 4924 Lasalle Avenue		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore	
9c. COUNTY OF DEATH City				10a. STATE Maryland		10b. COUNTY CITY	
10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 4924 Lasalle Avenue	
10f. ZIP CODE 21206				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 12				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) Louis Ruth				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Schlurpner			
19a. INFORMANT'S NAME (Type/Print) John Lee Ray				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 2913 Pemwood Court Bel Air, MD 21014			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garden of Faith Cemetery 8/10/91		20c. LOCATION — City or Town, State Kenwood, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Martin J. Dippel Jr.				22. NAME AND ADDRESS OF FACILITY Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD. 21206			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Liver Failure 2° to Cirrhosis DUE TO (OR AS A CONSEQUENCE OF): b. Alcohol Abuse DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Jeff Roshkowitz D.O.				29c. LICENSE NUMBER H-40717		29d. DATE SIGNED (Month, Day, Year) 8/8/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) Franklin Square Hospital Baltimore, MD 21237							
31. DATE FILED (Month, Day, Year) 8/8/91 AUG 9				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION



91 21777

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM N. SCHMITZ</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>8</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>219-07-5587</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>71</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 5, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2708 Gibbons Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2708 Gibbons Avenue</b>				10f. ZIP CODE <b>21214</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>V.P. &amp; Treas.</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Schmitz Printing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>E. John Schmitz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Noonan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Miss Jane C. Schmitz</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2708 Gibbons Avenue Baltimore, Maryland 21214</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery 8/12/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael J. Ruck</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ventricular arrhythmia</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): <b>stroke</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>arteriosclerosis</b> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide  28a. DATE OF INJURY (Month, Day, Year)  28b. TIME OF INJURY <b>M</b>  28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)  29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>Walter B. Koppel M.D.</i>  29c. LICENSE NUMBER <b>D15538</b>  29d. DATE SIGNED (Month, Day, Year) <b>August 9, 1991</b>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Walter B. Koppel, M.D. 1900 E. Northern Parkway</b>  31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>  32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Pandell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR TO THE PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.			
1. DECEDENT'S NAME (First, Middle, Last) <b>SMITH, ALLIE M. Smith</b>						2. DATE OF DEATH MONTH DAY YEAR <b>Aug. 7, 1991</b>				3. TIME OF DEATH <b>3:55 a.m. M</b>					
4. SOCIAL SECURITY NUMBER <b>218-18-2266</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87 YRS.</b>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>11/14/03</b>		8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>					
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1121 Elmridge Avenue</b>						10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>0</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Waitress</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Bowling Alley</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Charles E. Sisk</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Janie P. Corbin</b>									
19a. INFORMANT'S NAME (Type/Print) <b>M. Frank Cavey, Jr.</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1558 Sulphur Spring Road, Arbutus, Maryland 21227</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery</b>				20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Joseph J. Ambrose Jr.</b>						22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Maryland</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Generalized atherosclerosis of the cerebral and cardiac arteries</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Circulating anticoagulant</b>										Approximate interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Circulating anticoagulant</b>										24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James E. Taylor, M.D.</b>						29c. LICENSE NUMBER <b>D11815</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James E. Taylor, M.D., 900 S. Caton Ave. St. Agnes Hospital, Balto., Md. 21229</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21779

1. DECEDENT'S NAME (First, Middle, Last) Ellen Martz Triplett				2. DATE OF DEATH MONTH 8 DAY 07 YEAR 91		3. TIME OF DEATH 7 PM					
4. SOCIAL SECURITY NUMBER 178-20-6533		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 12/9/23		8. BIRTHPLACE (State or Foreign Country) PA			
9a. FACILITY NAME (If not institution, give street and number) 3917 Rayton Road				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown			9c. COUNTY OF DEATH Baltimore				
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 3917 Rayton Road				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? United States					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) College (1-4 or 5+) 12 years HS			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife			16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) George Martz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Mary Josephine Dutra							
19a. INFORMANT'S NAME (Type/Print) Mr. Willis F. Triplett				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3917 Rayton Road Randallstown, MD 21133							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park		DATE 8/10		20c. LOCATION — City or Town, State Sykesville, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James B. Covey				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Metastatic Breast Cancer Approximate Interval Between Onset and Death Syms 1 year a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
		28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Ross C. Donohue Assoc. Professor				29c. LICENSE NUMBER D23675				29d. DATE SIGNED (Month, Day, Year) 8-8-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 2) Type, Print Ross C. Donohue Johns Hopkins Hospital Baltimore, MD 21205											
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

07712 12

May 1-5

May 20-21

May 22-23

May 24-25  
May 26-27  
May 28-29  
May 30-31

TO THE HOSPITAL DEATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marjorie P. Toplonsky</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0845</b> M	
4. SOCIAL SECURITY NUMBER <b>184-12-0361</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>12-11-22</b>		8. BIRTHPLACE (State or Foreign Country)			
9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Middle River</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>209 Middleway Road Apt. 2c</b>		10f. ZIP CODE <b>21220</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9th</b> College (1-4 or 5+) <b>Computer Programmer</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Computer Programmer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Martin's</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Benjamin O. West</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vonethia Diehl</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Janis West</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>19425 Ensor Road White Hall Md. 21161</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Nicholas Cemetery</b>		20c. LOCATION — City or Town, State <b>Old Forge PA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Connelly Funeral Home</b>		22. NAME AND ADDRESS OF FACILITY <b>Connelly Funeral Home 300 Mace Ave. 21221</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>cardiopulmonary arrest</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>coronary cancer</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>renal failure</b> DUE TO (OR AS A CONSEQUENCE OF): d.		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Julien Thayer Johnson MD</b>	
29c. LICENSE NUMBER <b>D 27406</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)	
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <b>Asha Davidson-Randall</b>			

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21781

1. DECEDENT'S NAME (First, Middle, Last) <b>SHIRLEY TAYLOR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 06 91</b>				3. TIME OF DEATH <b>10 30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213 26 6025</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03 07 1928</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6522 SANZO RD</b>				10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>BRANCH CHIEF SECRETARY GOVERNMENT</b>				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT TAYLOR</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ESTHER WOLFE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>MISS GOLDIE TAYLOR</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6522 SANZO RD. BALTIMORE, MD 21209</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>OHEL YAKOV 8/8/91</b>		DATE <b>8/8/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RENAL FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>BREAST CANCER AND ENDOMETRIAL CANCER</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>RHEUMATIC HEART DISEASE</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. I. Cohen M.D.</i>	
29c. LICENSE NUMBER <b>027730</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GARY I. COHEN, M.D. 6565 N. CHARLES ST BALTO. MD 21204</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWARD TAYLOR</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>28</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>12:00 A M</b>		
4. SOCIAL SECURITY NUMBER		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>37</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-26-53</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>2964 MOSHER COURT</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH		
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore,</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>3440 Mondawmin Ave.</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		16b. KING OF BUSINESS/INDUSTRY <b>Construction</b>				
17. FATHER'S NAME (First, Middle, Last) <b>Elmer Taylor</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Beatrice Fraling</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Phyllis Kent</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3440 Mondawmin Ave. Balto, Md. 21216</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion Cem. 8-3-91</b>		20c. LOCATION — City or Town, State <b>Balto, Md.</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. 4611 Park Heights Ave. Balto 21215</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <u>stab wound of chest</u></b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d. DUE TO (OR AS A CONSEQUENCE OF):</b>							Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO						
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>HALLWAY</b>						
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>07 28 1991</b>		28b. TIME OF INJURY <b>12:00</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT STABBED</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>BUILDING</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2964 MOSHER COURT</b>				
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>7-28-1991</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETES CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A.M. DIXON 111 N. PENN STREET BALTIMORE, MARYLAND 21201</b>								
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE 						

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Anna B. Velle				2. DATE OF DEATH MONTH 8 DAY 07 YEAR 91		3. TIME OF DEATH 11:45 P M	
4. SOCIAL SECURITY NUMBER 212-22-5625		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 72 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4/17/19	
8. BIRTHPLACE (State or Foreign Country) Ohio				9a. FACILITY NAME (If not institution, give street and number) 4315 Holbrook Road		9b. CITY, TOWN OR LOCATION OF DEATH Randallstown	
9c. COUNTY OF DEATH Baltimore				10a. STATE Maryland		10b. COUNTY Baltimore	
10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER 4315 Holbrook Road	
10f. ZIP CODE 21133				10g. CITIZEN OF WHAT COUNTRY? United States		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No — If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years HS College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Machine Operator		16b. KIND OF BUSINESS/INDUSTRY Koppers Co.	
17. FATHER'S NAME (First, Middle, Last) Henry Bates				18. MOTHER'S NAME (First, Middle, Maiden Surname) Minnie Tollifer			
19a. INFORMANT'S NAME (Type/Print) Mr. Alexander Velle				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4315 Holbrook Road Randallstown, MD 21133			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Lake View Mem. Park 8/9		20c. LOCATION — City or Town, State Sykesville, MD	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lance B. Covey</i>				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Home 8728 Liberty Road Randallstown, MD 21133			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>ADENOCARCINOMA METASTATIC TO LIVER FROM UNKNOWN PRIMARY</i> Due to (or as a consequence of): b. Due to (or as a consequence of): c. Due to (or as a consequence of): d. Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>and [Signature] MD</i>		29c. LICENSE NUMBER D19419	
29d. DATE SIGNED (Month, Day, Year) 8/8/91				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DIANA H. GRIFFITHS 900 CATON AVE BARI. MD 21229			
31. DATE FILED (Month, Day, Year) AUG 9 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached for use as the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES W WOOLFORD</b>		2. DATE OF DEATH MONTH DAY YEAR <b>08 07 1991</b>		3. TIME OF DEATH <b>4:34 P M</b>	
4. SOCIAL SECURITY NUMBER <b>215-52-0072</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>6-30-49</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>		9. FACILITY NAME (If not Institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>810 McCABE AVENUE</b>		10f. ZIP CODE <b>21212</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11TH</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>D. MYERS SHOE COMPANY</b>		17. FATHER'S NAME (First, Middle, Last) <b>CHARLES WOOLFORD</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CLARA LEWIS</b>		19a. INFORMANT'S NAME (Type/Print) <b>CLARA WOOLFORD</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>810 McCABE AVE./BALTIMORE, MD 21212</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Erosive esophagitis</b> a. DUE TO (OR AS A CONSEQUENCE OF):  b. <b>AIDS - Acquired immune deficiency Syndrome</b> c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>1 1/2 months</b> <b>2 yrs.</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>8/7/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>L. H. Heston MD, Resident Physician</b>		29c. LICENSE NUMBER <b>J1990</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JHH 600 N. Wolfe St. Balt. MD 21205</b>		31. DATE FILED (Month, Day, Year) <b>8/7/AUG 9 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

#8V12 1P

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 21785

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Theresa G. Wood</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8- 7- 1991</b>		3. TIME OF DEATH <b>10:00 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-16-6111 A</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>74</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8-5-1917</b>		8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1929 Rettman Lane</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>DUndalk</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7810 Fairgreen Rd.</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Platzke Herman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Esther Wallace</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Joan Carter</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1929 Rettman Lane, DUndalk, Md. 21222</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. LOCATION — City or Town, State <b>8-8-91 Balto. Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Robert P. Harris</i>				22. NAME AND ADDRESS OF FACILITY <b>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd. Balto., Md. 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of lung with liver metastases</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div style="width: 60%;">                 a. DUE TO (OR AS A CONSEQUENCE OF):                  b. DUE TO (OR AS A CONSEQUENCE OF):                  c. DUE TO (OR AS A CONSEQUENCE OF):                  d.             </div> <div style="width: 35%; border-left: 1px solid black; padding-left: 5px;">                 Approximate Interval Between Onset and Death             </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>James A. [Signature]</i>				29c. LICENSE NUMBER <b>P16619</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>100 N. Broadway St. - BALTIMORE MD. 21231</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR OTHER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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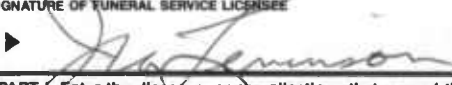



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

1 - FOR  
STATE  
REGISTRAR

REG. NO.

91 21786

1. DECEDENT'S NAME (First, Middle, Last) <b>IRMA WOLF</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUG. 1, 1991</b>		3. TIME OF DEATH <b>11:30 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>215-32-0897</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>93</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>10/5/1897</b>		8. BIRTHPLACE (State or Foreign Country) <b>GERMANY</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MT. WASHINGTON APT. 2551 STEELE RD</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2551 STEELE RD.</b>		10f. ZIP CODE <b>21209</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>				16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>		17. FATHER'S NAME (First, Middle, Last) <b>KARL KATZ</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CLARA LAUPHEIMER</b>				19a. INFORMANT'S NAME (Type/Print) <b>MRS. LILO BACHARACH</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6027 BERKELEY AVE. BALTIMORE, MD 21209</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CHEVRA AHAVAS CHESED 8/4/91</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Chronic renal failure</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.	
24. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Crown artery disease, Chronic disease, Anemia, Chronic disease, Hypertension</b>				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Thomas J. Lichtenfeld MD</b>		29c. LICENSE NUMBER <b>D18187</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>				29e. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.L. LICHTENFELD MD 4000 OLD COURT RD, PICOVILLE MD 21208</b>		30. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>	
31. REGISTRAR'S SIGNATURE 				32. REGISTRAR'S SIGNATURE			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51498

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21787							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>Genevieve Marie ZAJDEL</b>				2. DATE OF DEATH MONTH <b>August</b> DAY <b>8</b> , YEAR <b>1991</b>				3. TIME OF DEATH <b>3:45 A M</b>							
4. SOCIAL SECURITY NUMBER <b>217 07 6050</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		7. DATE OF BIRTH MONTH <b>Aug</b> , DAY <b>7</b> , YEAR <b>1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Sq. Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>				9c. COUNTY OF DEATH <b>Baltimore</b>							
RESIDENCE OF DECEDENT															
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Essex</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>533 S. Marlyn Ave.</b>				10f. ZIP CODE <b>21221</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>							
17. FATHER'S NAME (First, Middle, Last) <b>William Gutchner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Teresa Butzner</b>											
19a. INFORMANT'S NAME (Type/Print) <b>Leonard F. Zajdel, Husband</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>533 S. Marlyn Ave. Baltimore, Md. 21221</b>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) <b>Holly Hill Memorial Gardens 8/10/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., Md.</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bruzdinski Funeral Home PA 1407 Eastern Ave. Baltimore, Md. 21221</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Carcinoma of the Brain Metabolic</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Carcinoma of the Lung</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Gastric ulcer, perforated</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. Pidlaon M.D.</b>				29c. LICENSE NUMBER <b>D-15024</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. Pidlaon, M.D. 7811 Wise Avenue Baltimore, MD 21222</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 9 1991</b>				32. REGISTRAR'S SIGNATURE 											

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21788

1. DECEDENT'S NAME (First, Middle, Last) Catherine Ann Abbott				2. DATE OF DEATH MONTH DAY YEAR August 11, 1991				3. TIME OF DEATH 8:25 P.M.					
4. SOCIAL SECURITY NUMBER 218-32-9454		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) January 12, 1906 Maryland		8. BIRTHPLACE (State or Foreign Country)					
9a. FACILITY NAME (If not institution, give street and number) 3812 Offutt Road				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown				9c. COUNTY OF DEATH Baltimore					
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 3812 Offutt Road				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? U. S. A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: Caucasian					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (8-12) College (1-4 or 5 +) High School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife				16b. KIND OF BUSINESS/INDUSTRY Home					
17. FATHER'S NAME (First, Middle, Last) Samuel Uhler				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Catherine Griffin									
19a. INFORMANT'S NAME (Type/Print) Ruth Eileen Eckhardt				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 3812 Offutt Road Randallstown, MD 21133									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 8/14/91		DATE 8/14/91		20c. LOCATION — City or Town, State Pikesville, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph W. Kellner				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, INC. 8728 Liberty Rd. Randallstown, MD 21133-4784									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Colon Carcinoma Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. Metastatic Breast Carcinoma c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death 2 yrs 2 yrs					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER [Signature]		29c. LICENSE NUMBER D27034		29d. DATE SIGNED (Month, Day, Year) 8/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5310 Old Court Road Suite 201 Randallstown MD 21133													
31. DATE FILED (Month, Day, Year) AUG 12 1991		32. REGISTRAR'S SIGNATURE [Signature]											

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY E. ALAGNA</b>						2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 11, 1991</b>		3. TIME OF DEATH <b>2:28A</b>	
4. SOCIAL SECURITY NUMBER <b>212-28-8425</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/06/30</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>--</b>	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>CATONSVILLE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3 McINTOSH COURT APT. D</b>				10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>XXX</b>		14. RACE — American Indian, Black, White, etc. <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOMEMAKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>OWN HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EDWARD J. McCOURT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDNA M. WAXTER</b>					
19a. INFORMANT'S NAME (Type/Print) <b>FRANK ALAGNA (HUSBAND)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 McINTOSH COURT CATONSVILLE, MD 21228</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>LAKEVIEW CEMETERY</b>		DATE <b>8/14/91</b>		20c. LOCATION — City or Town, State <b>SYKESVILLE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>L. Russell Witzke</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Non Small Cell Lung Ca</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>c. DUE TO (OR AS A CONSEQUENCE OF):</b> <b>d.</b>								Approximate Interval Between Onset and Death <b>4 years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>COPD</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Kathy P. Miller MD</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>Aug 11, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Kathy P. Miller MD Tower 110 600 N. Broadway, Baltimore MD</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 29 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Charles W. Brooks</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 9, 1991</b>		3. TIME OF DEATH <b>4:20 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>223-01-8029A</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>July 15, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Meridan Long Green</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>-----</b>							
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore County</b>		10c. CITY, TOWN OR LOCATION <b>Towson</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>8548 Drumwood Road</b>				10f. ZIP CODE <b>21204</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>—</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Sales</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Auto</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Montague Brooks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sue Walker</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles W. Brooks, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12711 River Rd. Potomac, Md. 20854</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ashe-Robert Lawn Greenmount Crematory 8/12/91 Balto. Md.</b>		20c. LOCATION — City or Town, State <b>Richmond, Va.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John G. Reitz</i>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Balto. Md. 21212</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>C.A.D.</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CVA, ACUTE</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Davidson-Rendell</i>				29c. LICENSE NUMBER <b>005063 (MD)</b>		29d. DATE SIGNED (Month, Day, Year) <b>12 AUG 91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. J. Dixon Hills 3501 St. Paul St. Balto. Md. 21218</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0070

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for medical purposes.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the final-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WAYNE A. BOSWELL SR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 11 1991</b>		3. TIME OF DEATH <b>5:00 A. M</b>	
4. SOCIAL SECURITY NUMBER <b>276-24-1276</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>60</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>MAY 17, 1931</b>	
8. BIRTHPLACE (State or Foreign Country) <b>OHIO</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1116 BAKER AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>1116 BAKER AVENUE</b>	
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SCHOOL TEACHER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>EDUCATION</b>	
17. FATHER'S NAME (First, Middle, Last) <b>DONALD BOSWELL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GLADYS STOVER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>REOME BOSWELL (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1116 BAKER AVENUE BALTIMORE, MARYLAND 21207</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NORTHLAWN CEMETERY 8/15/91</b>		20c. LOCATION — City or Town, State <b>CANTON, OHIO</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Donna W. Lewis</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M. &amp; RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Acute renal failure</i>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jerome Ginsberg</i> M.D.				29c. LICENSE NUMBER <b>D20964</b>		29d. DATE SIGNED (Month, Day, Year) <b>0812-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JEROME GINSBERG M.D. 8630 LIBERTY PLAZA MALL, RANDALLSTOWN, MARYLAND 21133</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN/MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, of item 23, injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ETHEL BEAUFORD</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>248-90-7813</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-8-08</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Good Sam. Hosp.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO.</b>				9c. COUNTY OF DEATH	
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1725 E. 35th St</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Negro</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary <input checked="" type="checkbox"/> (0-12) College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		18b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Mathews</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Clemmie Ramsey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1725 E. 35th St. BALTO. MD 21218</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SAVANNA CREEK CEMET</b>		20c. LOCATION — City or Town, State <b>JAMESTOWN SC</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardio-Pulmonary Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Chronic Renal failure</b> <b>Hypertension</b> DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Chronic Renal failure</b> <b>Hypertension</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>NIL LAMTE LAMPTAY-MILLS MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NIL LAMTE LAMPTAY-MILLS 90 GOOD SAMARITAN HOSPITAL BALTIMORE</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GLADYS K. BURBANK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>8:10 PM</b>	
4. SOCIAL SECURITY NUMBER <b>216-05-1747</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-28-1903</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9. FACILITY NAME (If not institution, give street and number) <b>Belair Convalesarium</b>			
10. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				11. COUNTY OF DEATH <b>City</b>			
12a. STATE <b>Maryland</b>		12b. COUNTY <b>City</b>		12c. CITY, TOWN OR LOCATION <b>Baltimore</b>		12d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
13. STREET AND NUMBER <b>6116 Belair Rd.</b>				14. ZIP CODE <b>21206</b>		15. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		19. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
20. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		22. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
23. FATHER'S NAME (First, Middle, Last) <b>Robert E. L. Flashell</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Marie Gesberg</b>			
25. INFORMANT'S NAME (Type/Print) <b>Leona F. Getz</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3512 Hamilton Ave., Baltimore, MD. 21214</b>			
27a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		27b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 8-12</b>		27c. LOCATION — City or Town, State <b>Baltimore, MD.</b>		28. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Duane J. Kincaid</b>	
29. NAME AND ADDRESS OF FACILITY <b>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214</b>				30. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Circulatory Collapse</b>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerotic Heart Disease</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Schizophrenia</b>			
31. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		32. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		33. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Pending Investigation 3 <input type="checkbox"/> Accident 4 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		34. DATE OF INJURY (Month, Day, Year) <b>8/12/91</b>	
35. TIME OF INJURY <b>M</b>		36. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		37. DESCRIBE HOW INJURY OCCURRED		38. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
39. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				40. SIGNATURE AND TITLE OF CERTIFIER <b>Allen B. Bradley</b>		41. LICENSE NUMBER <b>D00426</b>	
42. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				43. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>		44. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>	
45. REGISTRAR'S SIGNATURE <b>Williamson-Rendell</b>				46. REGISTRAR'S SIGNATURE			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DEATH	
BALLENGER, Lulear		8, 9, 91		12:40 AM	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)	
251099583		1 <input checked="" type="checkbox"/> M <input type="checkbox"/> F		72 YRS.	
7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)		9. COUNTY OF DEATH	
4-10-1919		Greer, S.C.		BALTO.	
10. FACILITY NAME (If not institution, give street and number)		11. CITY, TOWN OR LOCATION OF DEATH		12. COUNTY OF DEATH	
Good Samaritan Hosp. 5601 Loch Raven Blvd.		BALTO.		BALTO.	
13. STATE		14. COUNTY		15. CITY, TOWN OR LOCATION	
Md.				Baltimore	
16. STREET AND NUMBER		17. ZIP CODE		18. CITIZEN OF WHAT COUNTRY?	
1200 Glenwood Ave.		21239		USA	
19. MARITAL STATUS		20. WAS DECEDENT EVER IN U.S. ARMED FORCES?		21. WAS DECEDENT OF HISPANIC ORIGIN?	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
22. DECEDENT'S EDUCATION		23. DECEDENT'S USUAL OCCUPATION		24. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)		Shipfitter			
25. FATHER'S NAME (First, Middle, Last)		26. MOTHER'S NAME (First, Middle, Maiden Surname)			
Robert Ballenger		Ida Drummond Ballenger			
27. INFORMANT'S NAME (Type/Print)		28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)			
Rev. Lucy Ingram Ballenger		1200 Glenwood Ave. BALTO, MD 21239			
29. METHOD OF DISPOSITION		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		31. DATE	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Woodlawn Cemetery		8/13	
32. SIGNATURE OF FUNERAL SERVICE LICENSEE		33. NAME AND ADDRESS OF FACILITY		34. LOCATION - City or Town, State	
Baltimore Funeral Home		William C. Bean Community Funeral Home 1206 W. North Ave. BALTO, MD.		BALTO, MD.	
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		36. IMMEDIATE CAUSE (Final disease or condition resulting in death)		37. Approximate Interval Between Onset and Death	
		a. Respiratory failure.		minutes	
		b. Severe bilateral pneumonia			
		c. Terminal lung cancer			
		d. Chronic Heart failure.			
38. PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I.		39. WAS AN AUTOPSY PERFORMED?		40. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
(L) pneumorectomy.		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
41. WAS CASE REFERRED TO MEDICAL EXAMINER?		42. PLACE OF DEATH (Check only one)			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
43. MANNER OF DEATH		44. DATE OF INJURY		45. TIME OF INJURY	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. (Month, Day, Year)		M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
46. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify)		47. DESCRIBE HOW INJURY OCCURRED		48. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
49. CERTIFIER (Check only one)		50. CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		51. MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN 2 <input type="checkbox"/> MEDICAL EXAMINER					
52. SIGNATURE AND TITLE OF CERTIFIER		53. LICENSE NUMBER		54. DATE SIGNED (Month, Day, Year)	
Wail Assy MD				8/9/91	
55. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		56. DATE FILED (Month, Day, Year)		57. REGISTRAR'S SIGNATURE	
Wail Assy 5601 Loch Raven Blvd. - Balt. 21228		8/9/AUG 12 1991		Julia Davidson-Randall	

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REG. NO.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MAUDE BENNETT</b>				2. DATE OF DEATH MONTH <b>08</b> - DAY <b>03</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>8:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-12-3203</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-08-1908</b>	
8. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>		10. COUNTY OF DEATH <b>BALTIMORE</b>	
11a. STATE <b>MD.</b>		11b. COUNTY <b>BALTIMORE</b>		11c. CITY, TOWN OR LOCATION <b>Maryland Line</b>		11d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
12. STREET AND NUMBER <b>21609 YORK ROAD</b>				13. ZIP CODE <b>21105</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		16. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		17. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		18. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
19. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		20. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Laborer</b>		21. KIND OF BUSINESS/INDUSTRY <b>Food Processing</b>			
22. FATHER'S NAME (First, Middle, Last) <b>Frank Huffman</b>				23. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lena Bush</b>			
24. INFORMANT'S NAME (Type/Print) <b>Linda L. Lee</b>				25. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4404 Miller Rd., Stewartstown, PA 17363</b>			
26. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		27. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Freedom Cemetery 8/6/91</b>		28. DATE <b>8/6/91</b>		29. LOCATION — City or Town, State <b>New Freedom, PA</b>	
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles T. Bowen</i>				31. NAME AND ADDRESS OF FACILITY <b>J.J. Hartenstein Mortuary, Inc. 24 Second St., New Freedom, PA 17349</b>			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPTIC SHOCK 2° TO INFECTIOUS PNEUMONITIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>ASPIRATION</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>MASSIVE RIGHT SIDED CVA</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
33. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				34. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		35. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
36. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				37. DATE OF INJURY (Month, Day, Year) <b></b>		38. TIME OF INJURY <b>M</b>	
39. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				40. DESCRIBE HOW INJURY OCCURRED <b></b>		41. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>	
42. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
43. SIGNATURE AND TITLE OF CERTIFIER <i>Enp. It. M.D.</i>				44. LICENSE NUMBER <b>D 23034</b>		45. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
46. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EDWARD P. KOZA, M.D. : 6701 N. CHARLES ST. : BALT., MD</b>							
47. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				48. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR OTHER FACILITY: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51352

Charles T. ...

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TAL TRA 37896  
DR. CUSHING  
CHESWICK, MD  
91 21797

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HELEN R. CHESWICK</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:43 A M</b>	
4. SOCIAL SECURITY NUMBER <b>215 10 8477</b>		5. SEX <b>1 M 2 F</b>	6. AGE (In yrs. last birthday) <b>80</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>1/21/11</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIV OF MD, SHOCK-TRAUMA HOSP</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>=====</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>LINTHICUM</b>	
10d. INSIDE CITY LIMITS? <b>1 YES 2 NO</b>				10e. STREET AND NUMBER <b>6314 ORCHARD RD</b>		10f. ZIP CODE <b>21090</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS <b>1 NEVER MARRIED 2 MARRIED 3 WIDOWED 4 DIVORCED</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 NO</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No - If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 NO</b>				14. RACE - American Indian, Black, White, etc. <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cashier</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Crown, Cork &amp; Seal</b>		17. FATHER'S NAME (First, Middle, Last) <b>Teofil Heyda</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary R.</b>				19a. INFORMANT'S NAME (Type/Print) <b>Alexander Cheswick</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6314 ORCHARD RD, BALT, MD 21090</b>	
20a. METHOD OF DISPOSITION <b>1 BURIAL 2 CREMATION 3 REMOVAL FROM STATE 4 DONATION 5 OTHER (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>St. Stanislaus Cemetery 8/13</b>		20c. LOCATION - City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>C Richard Gonce</b>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>CARDIAC ARREST</b> <b>CERVICAL SPINE INJURY</b> <b>FALL DOWN STAIRS AT HOME</b>	
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 NO</b>	
26. PLACE OF DEATH (Check only one) <b>HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)</b>				27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>		28a. DATE OF INJURY (Month, Day, Year) <b>8/8/91</b>	
28b. TIME OF INJURY <b>P M</b>				28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE HOW INJURY OCCURRED <b>FALL DOWN STAIRS</b>	
28e. PLACE OF INJURY - At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>6314 Orchard Rd</b>		29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael Sauter, MD</b>				29c. LICENSE NUMBER <b>D38092</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DEPT CRITICAL CARE, MIEMSS, 22 SO. GREENE ST</b>				31. DATE FILED (Month, Day, Year) <b>8/10/91</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

LEGAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. The funeral director, after this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 12 1971

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ITEMS: 23, 27 per ME  
G-678 8/27/91 cm  
91-4543-025

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Marion Franklin Crutchfield				2. DATE OF DEATH MONTH DAY YEAR 08 07 1991				3. TIME OF DEATH 11:00 a M	
4. SOCIAL SECURITY NUMBER 558-22-0708		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) 7/13/17		8. BIRTHPLACE (State or Foreign Country) Arkansas	
9a. FACILITY NAME (If not institution, give street and number) 105 N. Washington Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Harve De Grace				9c. COUNTY OF DEATH Harford	
10a. STATE Maryland		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Harve De Grace				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 105 N. Washington Street				10f. ZIP CODE 21078		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES W W 2 & Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 1 Year		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Master Chief Petty Officer		16b. KIND OF BUSINESS/INDUSTRY US Navy					
17. FATHER'S NAME (First, Middle, Last) Thomas Franklin Crutchfield				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Marie Stevenson					
19a. INFORMANT'S NAME (Type/Print) Mrs. Mary Ellen Griffin				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 6732 Bonnie Ridge Drive Apt. 201 Balto. MD 21209					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Carroll Cremation Services 8/10		DATE 8/10		20c. LOCATION — City or Town, State Hampstead, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Stephen M Jenkins				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD 21133					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → HYPERTENSIVE ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Dennis J. Chute MD				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08 09 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 111 Penn Street, Baltimore Maryland 21201									
31. DATE FILED (Month, Day, Year) AUG 12 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State of Maryland Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 29 is marked, or item 30 is marked, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked as item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH			
ROBERT HENRY DAVIS				8 8 91				8:46 P M			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
240 36 1908		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		64 YRS.		9 9 27		NORTH CAROLINA			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
VA MEDICAL CENTER				FORT HOWARD				BALTIMORE			
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
MARYLAND				BALTIMORE		BALTIMORE				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
601 WYANOKE AVENUE APT 301				21218				USA			
11. MARITAL STATUS		12. WAS DECEASED EVER IN U.S. ARMED FORCES?		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: WORLD WAR II		Specify: BLACK					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced											
15. DECEASED'S EDUCATION (Specify only highest grade completed)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) 6th				College (1-4 or 5 +)				CABINET MAKER			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
ROBERT DAVIS				DELIA (BRIGHT)							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
MAGGIE DAVIS				601 WYANOKE AVE./BALTIMORE, MD 21218							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		GARRISON FOREST VA CEM.		OWINGS MILLS, MD							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Calvin L. Williams				MARCH FUNERAL HOME 1101 E. NORTH AVE., BALTIMORE, MD. 21202							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. PULMONARY EMBOLISM, RIGHT PULMONARY ARTERY DUE TO (OR AS A CONSEQUENCE OF):											
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. PULMONARY ASPIRATION, ACUTE DUE TO (OR AS A CONSEQUENCE OF):											
c. DUE TO (OR AS A CONSEQUENCE OF):											
d. DUE TO (OR AS A CONSEQUENCE OF):											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined											
3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				[Signature]				MD 015232		8/10/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
RAOUL IVAN LOPEZ MD MPH VAMC				AUG 12 1991				Julia Davidson-Randall			

SECRET

91 21800

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE ALBERT DORBERT</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:00</b> M	
4. SOCIAL SECURITY NUMBER <b>219-30-9933</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11/1/05</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7401 German Hill Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7401 German Hill Road</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>3 years</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Caretaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Sacred Heart of Jesus Cemetery</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George J. Dorbert</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Barbara Seifert</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Louise Kline</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4513 Woodlea Ave. Balto. Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cem. Balto. County</b>		20c. LOCATION — City or Town, State <b>Balto. County</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Catherine M. Zeiler</b>				22. NAME AND ADDRESS OF FACILITY <b>Lilly &amp; Zeiler, Inc. Funeral Home 1901 Eastern Ave. 21231</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>DISEASE</b> <b>ARTERIOSCLEROTIC CORONARY VASCULAR</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ABDOMINAL AORTIC ANEURYSM</b> <b>TYPE II DIABETES MELLITUS</b> <b>WEIGHT LOSS</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. M. H. Hoff</b>				29c. LICENSE NUMBER <b>D29197</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. M. NIENHOFF 9000 FRANKLIN SQUARE DR. BALTO, MD 21237</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 6 and 7 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH REG. NO.

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Concetta D'Angelo</b>		2. DATE OF DEATH MONTH <b>August</b> DAY <b>9</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>0958 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-10-8660</b>		5. SEX <b>1</b> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 7, 1919</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		9a. FACILITY NAME (If not institution, give street and number) <b>PENINSULA GENERAL HOSPITAL</b>	
9b. CITY, TOWN OR LOCATION OF DEATH <b>SALISBURY</b>		9c. COUNTY OF DEATH <b>WICOMICO</b>		10a. STATE <b>MD</b>	
10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8323 Kendale Road</b>		10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input type="checkbox"/> Married <b>3</b> <input checked="" type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6 years</b> College (1-4 or 5+) -----		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Glen Eagle Clothing</b>		17. FATHER'S NAME (First, Middle, Last) <b>Joseph Paterniti</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Angelina Curcuruto</b>	
19a. INFORMANT'S NAME (Type/Print) <b>Joan Cascio</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1809 Dalhousie Court Apt. A 1 Balto., MD 21234</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Cemetery 8/13</b>		20c. LOCATION — City or Town, State <b>Timonium, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John E. Solar</i>		22. NAME AND ADDRESS OF FACILITY <b>Johnson Funeral Home 8521 Loch Raven Blvd. Towson, MD 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b>		a. <b>Concise Cause</b> DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death <b>MIN</b>	
b. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):		c. <b>ASCVD</b> DUE TO (OR AS A CONSEQUENCE OF):		<b>DAYS</b>	
d. _____ DUE TO (OR AS A CONSEQUENCE OF):				<b>YRS</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebral Thrombosis</b>		24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input checked="" type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald M. Wood MD</b>		29c. LICENSE NUMBER <b>W3311</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>D. M. Wood, MD PHM</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21802

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DAVID CLIFTON ENNIS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>577-18-6189</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-20-21</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1608 DREXEL STREET</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TAKOMA PARK</b>	
9c. COUNTY OF DEATH <b>Prince George</b>				10a. STATE <b>MD</b>		10b. COUNTY <b>PRINCE GEORGE</b>	
10c. CITY, TOWN OR LOCATION <b>TAKOMA PARK</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1608 DREXEL STREET</b>	
10f. ZIP CODE <b>20912</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>3</b> <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Trucking Co.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Frank Ennis</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Wilkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jerry W. Stevens</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7729 Ogden Ct., Falls Church, VA 22043</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or place) <b>8-10-91 Oak Hill Cemetery</b>		20c. LOCATION — City or Town, State <b>Fredericksburg, VA.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Michael C. Anderson</b>				22. NAME AND ADDRESS OF FACILITY <b>Mullins &amp; Thompson Funeral Service 1621 Jeff Davis Hwy. Fredericksburg, VA 22401</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Arteriosclerotic Cardiovascular Disease</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death <b>minutes</b> <b>years</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.     						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA <b>OTHER:</b> <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paul A. Devore, MD, Medical Examiner</b>			
29c. LICENSE NUMBER <b>501852</b>				29d. DATE SIGNED (Month, Day, Year) <b>8-8-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PAUL A. DEVORE, MD 4203 QUEENSBURY RD HYATTSVILLE MD 20781</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jake Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN. The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR AND THE CORONER. This certificate has been signed by the attending physician and completely filled in by the funeral director; page 5 should be detached for use as the burial-transit certificate and filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If item 28 is marked or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY T. FLORA</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>3:45 a m</b>	
4. SOCIAL SECURITY NUMBER <b>215-56-6196</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>40</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>June 8, 1951</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>6917 Harford Road</b>	
10f. ZIP CODE <b>21234</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>2</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Data Technician</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Balto. County School System</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Norman W. Flora Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Constance M. Vitale</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Constance Dewey</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3 Thurmont Court T-D Baltimore, Md. 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>Most Holy Redeemer Aug. 14, 1991</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James J. Bladden</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Gunshot wound of chest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) <b>08/11/1991</b>		28b. TIME OF INJURY <b>1:58a m</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>PARKING LOT</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1631 EAST JOPPA ROAD BALTIMORE, MARYLAND</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Am. Dixon</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/11/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Am. Dixon 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Galia Davidson-Rodriguez</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51904

91 21805

FOR  
STATE REGISTRAR MARY VIRGINIA FOWLER  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Mary V Fowler</i>				2. DATE OF DEATH 08/10/91 MONTH DAY YEAR 8 10 91				3. TIME OF DEATH 7:45 AM			
4. SOCIAL SECURITY NUMBER 217-66-2677				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/18/06		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH ----	
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION WOODSTOCK				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 11 OFFUTT COURT						10f. ZIP CODE 21163		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12th College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STENOGRAPHER/SECRETARY				16b. KIND OF BUSINESS/INDUSTRY B. & O. RAILROAD			
17. FATHER'S NAME (First, Middle, Last) WILLIAM C. DONNELLY						18. MOTHER'S NAME (First, Middle, Maiden Surname) ALICE JEWELL FULWOOD					
19a. INFORMANT'S NAME (Type/Print) WILLIAM FOWLER (SON)						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 OFFUTT COURT WOODSTOCK, MD 21163					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) MORELAND MEMORIAL PARK 8/13/91 BALTIMORE, MD				20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edmund C. Trank</i>						22. NAME AND ADDRESS OF FACILITY LEROY M & RUSSELL C WITZKE FUNERAL HOME 1630 EDMONDSON AVE CATONSVILLE, MD 21228					
<p>PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.</p> <p>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Sepsis</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):</p> <p>c.  DUE TO (OR AS A CONSEQUENCE OF):</p> <p>d.  DUE TO (OR AS A CONSEQUENCE OF):</p>											
<p>PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Congestive Heart Failure</i></p>											
23. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> ODA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)				28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edmund C. Trank</i>						29c. LICENSE NUMBER D34C51		29d. DATE SIGNED (Month, Day, Year) 8/10/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Edmund C. Trank 413 Commonwealth Dr Baltimore 21228											
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE <i>J. A. Fowles-Rendell</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State-County of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, a legal death was shown any injury, or other traumatic event, the medical examiner must be notified at once.

*James J. [unclear]*



91 21806

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) BRYAN K. HARPER				2. DATE OF DEATH MONTH DAY YEAR AUGUST 10 1991		3. TIME OF DEATH 6:30 A.M.	
4. SOCIAL SECURITY NUMBER 220-76-6236		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 31 YRS.		7. DATE OF BIRTH (Month, Day, Year) DEC. 4, 1959	
9a. FACILITY NAME (If not institution, give street and number) 100 5th AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH LANSDOWNE		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION LANSDOWNE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER 100 5th AVENUE				10f. ZIP CODE 21227		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) _____		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) ELECTRICIAN		16b. KIND OF BUSINESS/INDUSTRY CONSTRUCTION			
17. FATHER'S NAME (First, Middle, Last) CHARLES HARPER				18. MOTHER'S NAME (First, Middle, Maiden Surname) VIRGINIA CODY			
19a. INFORMANT'S NAME (Type/Print) DAWN M. HARPER (WIFE)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 100 5th AVENUE LANSDOWNE, MARYLAND 21227					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) _____		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GLEN HAVEN CEMETERY 8/13/91		20c. LOCATION — City or Town, State GLEN BURNIE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy M. Witzke</i>				22. NAME AND ADDRESS OF FACILITY LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE, CATONSVILLE, MD. 21228			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. METASTATIC lung cancer DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric Rowinsky</i>				29c. LICENSE NUMBER m 10886		29d. DATE SIGNED (Month, Day, Year) 08-12-91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) ERIC ROWINSKY M.D. 600 N. WOLFE STREET, BALTIMORE, MARYLAND 21205							
31. DATE FILED (Month, Day, Year) AUG 12 1991		32. REGISTRAR'S SIGNATURE <i>Eric Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, other traumatic event, the medical examiner must be notified at once.

21 31809

*James M. Smith*

2

91 21807

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Adrian Hatmaker</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:15 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>406 03 2497</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/14/1914</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1910 Ramsay Street</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>=====</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>=====</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1910 Ramsay Street</b>	
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7th Grade</b> College (1-4 or 5+) <b>=====</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Loader</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Cloverland Milk</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Wheeler Hatmaker</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Minda Tiller</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary L. Hatmaker</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1910 Ramsay Street Baltimore, Maryland 21223</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cemetery</b>		20c. LOCATION — City or Town, State <b>8-12 Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Richard E. Davis</i>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. DEMENTIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. =====</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. =====</b>							Approximate Interval Between Onset and Death <b>&gt;10 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ATRIAL FIBRILLATION</b> <b>H/O GI BLEED</b> <b>COLD, H/O ASPIRATION PNEUMONIA</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>N/A</b>		28b. TIME OF INJURY <b>N/A</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David Kumstak MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID KUMSTAK - UMD Hosp. DEPT OF MEDICINE, 22 GREENE ST.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician, and the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21808

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THOMAS J. IRWIN, JR</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08-07-91</b>		3. TIME OF DEATH <b>11 AM</b>	
4. SOCIAL SECURITY NUMBER <b>705 03 9559</b>		5. SEX <b>1 M 2 F</b>		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8/22/1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7768 Edgewood Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>	
9c. COUNTY OF DEATH <b>Anne Arundel</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Pasadena</b>				10d. INSIDE CITY LIMITS? <b>1 YES 2 X NO</b>		10e. STREET AND NUMBER <b>7768 Edgewood Avenue</b>	
10f. ZIP CODE <b>21122</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <b>1 NEVER MARRIED 2 X MARRIED 3 WIDOWED 4 DIVORCED</b>	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 YES 2 X NO</b> IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 8th Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Stationary Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>City of Baltimore</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas J. Irwin Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Frances Schelhaus</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dolores Kraynak</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2597 Treehouse Drive Woodbridge, Virginia 22192</b>			
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Memorial Park</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Richard C Davis</b>				22. NAME AND ADDRESS OF FACILITY <b>George J. Gonce Funeral Home P.A. 4001 Ritchie Hwy. Baltimore, Md. 21225</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>probable cardiac arrhythmia minutes</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>hypertension / pre-systolic day</b> <b>natural senescence / failure-to-thrive (weeks)</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>probable infantile dementia</b>							
24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 X NO</b>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 6 Other (Specify)</b>			
27. MANNER OF DEATH <b>1 Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 6 Could not be determined</b>				28. DATE OF INJURY (Month, Day, Year) <b>8/07/91</b>			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <b>1 YES 2 X NO</b>				28d. DESCRIBE HOW INJURY OCCURRED			
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James O. Shorbeck, M.D.</b>				29c. LICENSE NUMBER <b>D29767</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/07/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. J. Shorbeck, M.D. 8418 B+A Blvd Pasadena, Md 21122</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Johnson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 09 1991</b>				3. TIME OF DEATH <b>1:58 P M</b>	
4. SOCIAL SECURITY NUMBER <b>264-36-3587</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-17-28</b>		8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>1331 W. North Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1331 W. North Ave.</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>TRACKMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Railroad</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Doc Smith</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Vellie Johnson</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Peggy L. Johnson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1409 Stonewood Rd. Balto, Md 21239</b>					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore Cemetery 8-16</b>		20c. LOCATION — City or Town, State <b>BALTO, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Baker A. B.</b>				22. NAME AND ADDRESS OF FACILITY <b>William C. Brown Community Funeral Home 1206 W. North Ave. Balto, Md.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. <b>CIRRHOSIS OF LIVER</b> DUE TO (OR AS A CONSEQUENCE OF):									
b. <b>CHRONIC ALCOHOLISM</b> DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO									24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mario F. Gold, Jr. MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 10 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLD, JR. MD 1206 W. North Avenue, Baltimore Maryland 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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[Faint, illegible text and markings are visible across the page, including what appears to be a signature or stamp near the bottom center.]



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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDWIN RICHARD KELLY</b>				2. DATE OF DEATH MONTH <b>AUG</b> DAY <b>7</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>12:10</b> P M	
4. SOCIAL SECURITY NUMBER <b>110-09-7106</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>AUG 18 1919</b>	
8. BIRTHPLACE (State or Foreign Country) <b>JAPAN</b>				9a. FACILITY NAME (If not institution, give street and number) <b>NATIONAL NAVAL MEDICAL CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BETHESDA</b>	
9c. COUNTY OF DEATH <b>MONTGOMERY</b>				10a. STATE <b>VIRGINIA</b>		10b. COUNTY <b>FAIRFAX</b>	
10c. CITY, TOWN OR LOCATION <b>FALLS CHURCH</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7414 NIGH ROAD</b>	
10f. ZIP CODE <b>22043</b>				10g. CITIZEN OF WHAT COUNTRY? <b>UNITED STATES</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1941 - 1962</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>U. S. NAVY</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DEFENSE</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>EDWIN WASHINGTON KELLY</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EDNA LOUISE TUCKER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLORIA M. KELLY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7414 NIGH ROAD, FALLS CHURCH, VA 22043</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Northern VA Crematory 8/9/91</b>		20c. LOCATION — City or Town, State <b>Arlington, VA</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>William A. Hargal</i>				22. NAME AND ADDRESS OF FACILITY <b>Murphy Falls Church Funeral Home, 1102 W. Broad St, Falls Church, VA</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>METASTATIC TRANSITIONAL CARCINOMA OF THE BLADDER</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				27. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Clay E. McTear MD</i>				29c. LICENSE NUMBER <b>14720 (S. CAROLINA)</b>		29d. DATE SIGNED (Month, Day, Year) <b>Aug 7 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A. E. MCLUCKIE, LT. MC. USN</b>				31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>			
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MINNA KRISTAPSONS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 10, 1991</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>218-36-7449</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>04-24-09</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Latvia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>LAPLATA MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>LAPLATA</b>	
9c. COUNTY OF DEATH <b>Charles</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Arbutus</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5300 East Drive</b>	
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 grade</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>self</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Barber</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Fricis Priede</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Ania Ratermanis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>P.O. Box 125 Charlotte Hall Md. 20622</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 8/13/91</b>		20c. LOCATION — City or Town, State <b>Baltimore City</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Ambrose Funeral Home, Inc. 1328 Sulphur Spring Rd. Arbutus, Md. 21227</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>myocardial infarction</b> Approximate Interval Between Onset and Death <b>hours</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>atherosclerotic cardiovascular disease</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary of heart Dilated cardiomyopathy</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>NA</b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>024781</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-10-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CHARLES R. GRAHAM JR., 295 FREDERICK RD. BALTIMORE, MD 21218</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT C. LANGHANS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10<sup>05</sup> p m</b>	
4. SOCIAL SECURITY NUMBER <b>213-03-8044</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-14-98</b>	
8. BIRTHPLACE (State or Foreign Country) <b>AUSTRIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>STELLA MARIS</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Md.</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3701 Hamilton Avenue</b>			
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>machinest</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Langhans</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha lauber</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Edward A. Langhans</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3701 Hamilton Avenue Baltimore, Md. 21206</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Aug. 14, 1991</b>		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James Bladden</b>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. UPPER RESPIRATORY INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. CHRONIC ORGANIC PULMONARY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF):  <b>d.</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input checked="" type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8-10-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ABRAM I PAKCHI</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21813

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Estelle B. Myers</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>12:30 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>212-01-8165</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-3-1897</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Inns of Evergreen</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>City</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>2829 Creston Rd.</b>			
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>8 Yrs.</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>William Myers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelea Martin</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Costa</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2829 Creston Rd., Dundalk, Md. 21222</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corp. 8-12-91</b>		20c. LOCATION — City or Town, State <b>Towson, Md.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Roy H. Cather</b> <i>Roy H. Cather</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiorespiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Lymphatic Leukemia</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>years</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ST Remote Myocardial Infarction</b> <b>Compensated Congestive Heart Failure</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Albert B. Bradley MD</b>				29c. LICENSE NUMBER <b>D00426</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Albert B. Bradley 4900 Belair Road Baltimore, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21814

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gene McCarthy</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 8, 1991</b>		3. TIME OF DEATH <b>3:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>218-22-0044</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 18, 1902</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5416 Pembroke Avenue</b>			
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4</b> College (1-4 or 5+) <b>4</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Civil Engineer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U.S. Army</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph McCarthy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Delia Guthrie</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Michael S. McCarthy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3326 Hazelwood Drive Fallston, Md. 21047</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 8/12/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton J. Knight Jr</b>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Acute Cardiac Arrest</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertensive Arteriosclerotic C-V Disease years</b> DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death <b>—</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>Hypercholesterolemia II A</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>in automobile</b>				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Albert B. Bradley M.D.</b>				29c. LICENSE NUMBER <b>D 00426</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Albert B. Bradley M.D. 4900 Belair Road Baltimore, Maryland</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


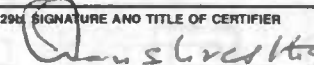

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ITEM:4 per FH  
G-679 9/9/91 cm

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21815

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERTA</b>		2. DATE OF DEATH MONTH DAY YEAR <b>August 1, 1991</b>		3. TIME OF DEATH <b>10:40A</b>	
4. SOCIAL SECURITY NUMBER <b>195-34-4581</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>Oct 20, 1907</b>		8. BIRTHPLACE (State or Foreign Country) <b>PENNA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Memorial Hospital &amp; Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Cumberland</b>		9c. COUNTY OF DEATH <b>Allegany</b>	
10a. STATE <b>PENNA</b>		10b. COUNTY <b>BEDFORD</b>		10c. CITY, TOWN OR LOCATION <b>EVERETT PA, 15537</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>11 4 N. SPRING ST.,</b>		10f. ZIP CODE <b>15537</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HAIRDRESSER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>BEAUTY SHOP</b>	
17. FATHER'S NAME (First, Middle, Last) <b>HOWARD P. SCHETROMPF</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GERTRUDE FLETCHER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MR. KENNETH NOEL</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>114 .N. SPRING ST., EVERETT PA, 15537</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>EVERETT CEMETERY 8-3-91</b>		20c. LOCATION — City or Town, State <b>EVERETT PA, 15537</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>DALLA VALLE FS IN CPO BO X179 EVERETT PA, 15537</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Cardiac failure</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Ischemic Cardiomyopathy</b> <b>Aspiration Pneumonitis</b>					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		27. DATE OF INJURY (Month, Day, Year)		27b. TIME OF INJURY <b>M</b>	
27c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		27d. DESCRIBE HOW INJURY OCCURRED		27e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>M.D.</b>		29c. LICENSE NUMBER <b>D20258</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/1/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Shresta Memorial Hospital Medical Building, Cumberland, MD 21502</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is completed, it must be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21816

1. DECEASED'S NAME (First, Middle, Last) Dorothy Marie Poist				2. DATE OF DEATH MONTH DAY YEAR August 9, 1991		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 216-12-9461		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 69 YRS.		7. DATE OF BIRTH (Month, Day, Year) June 4, 1922		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) 3819 Fernside Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Randallstown				9c. COUNTY OF DEATH Baltimore County			
10a. STATE Maryland		10b. COUNTY Baltimore County		10c. CITY, TOWN OR LOCATION Randallstown				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 3819 Fernside Rd.				10f. ZIP CODE 21133		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) 12th Grade College (1-4 or 5+) College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Benjamin Franklin Pierpont				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rose Cecelia Lorenzo							
19a. INFORMANT'S NAME (Type/Print) Mrs. Sharon Kay				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5082 Amantea Way Sykesville, MD 21784							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) New Cathedral Cemetery 8-12-91		DATE		20c. LOCATION — City or Town, State Baltimore City, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE John K. Arnold				22. NAME AND ADDRESS OF FACILITY Loring Byers Funeral Directors, Inc. 8728 Liberty Rd. Randallstown, MD 21133							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Atherosclerosis, Cardiovascular Disease DUE TO (OR AS A CONSEQUENCE OF): Hypertension Diabetes DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death year year year											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER D27034		29d. DATE SIGNED (Month, Day, Year) 08/12/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 5310 Old Court Road Suite 201 Randallstown MD 21133											
31. DATE FILED (Month, Day, Year) AUG 12 1991		32. REGISTRAR'S SIGNATURE									

01013 10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician and completely filled in by the funeral director. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21817

1. DECEDENT'S NAME (First, Middle, Last) <b>HENRY W. PAFF</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>'91</b>				3. TIME OF DEATH <b>4:50 P.M.</b>					
4. SOCIAL SECURITY NUMBER <b>219-12-9678</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>02-10-25</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER TOWSON, .D.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore County</b>		10c. CITY, TOWN OR LOCATION <b>Lutherville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1017 Adcock Road</b>				10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 yrs.</b> College (1-4 or 5+) <b>n/a</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Taxicab driver</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Taxicab company</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Harry Paff</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Moudry</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Robert M. Paff</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1017 Adcock Rd. Lutherville, MD. 21093</b>									
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Cemetery 08/12/91</b>				20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John G. Reitz</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>ENCEPHALOPATHY</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>CVA</b> DUE TO (OR AS A CONSEQUENCE OF):  d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <b>Phillip N. Phillips MD</b>		29c. LICENSE NUMBER <b>D36908</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>PHILLIP N. PHILLIPS MD 500 MAIN ST., REISTERSTOWN</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>									

1815 12

2



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21818

1. DECEDENT'S NAME (First, Middle, Last) Tiffany Ann PENNINGTON				2. DATE OF DEATH MONTH 8 DAY 7 YEAR 91		3. TIME OF DEATH 11:42 A.M.				
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 1 hour YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 7, 1991		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) Franklin Square Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore			9c. COUNTY OF DEATH Baltimore			
10a. STATE MD			10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Baltimore			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 12 Banca Place				10f. ZIP CODE 21220		10g. CITIZEN OF WHAT COUNTRY? USA				
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) David M. Pennington				18. MOTHER'S NAME (First, Middle, Maiden Surname) Cathy A. Berkenkemper						
19a. INFORMANT'S NAME (Type/Print) David & Cathy Pennington				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 12 Banca Place Baltimore, MD 21220						
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Mem. Gardens			20c. LOCATION — City or Town, State Timonium, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>David L. Ebaugh</i>				22. NAME AND ADDRESS OF FACILITY Johnson Funeral Home 8521 Loch Raven Blvd. Balto., MD 21204						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Extreme Prematurity Due to (or as a consequence of): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST Due to (or as a consequence of): Approximate Interval Between Onset and Death										
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Premature Labor							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
			28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Rijhsinghani MD</i>						29c. LICENSE NUMBER 01322		29d. DATE SIGNED (Month, Day, Year) 8.7.91		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Asha Rijhsinghani, MD 9105 Franklin Sq. Dr., Balto., MD 21237										
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>						

01010 10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completed and filed by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH	
Albert J. Rush				Aug. 10, 1991				6:26 P. M.	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)	
214-18-3611		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		67 YRS.		Mar. 13, 1924		Maryland	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
7036 Conley Street				Baltimore Co. Md.				Baltimore	
10a. STATE				10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
Maryland				Baltimore		Baltimore		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
7036 Conley Street				21224		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: White			
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		WW II							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
Elementary/Secondary (0-12) College (1-4 or 5+)				Bricklayer				Construction	
12				0					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
William Rush				Theresa Otremba					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Jeanette Rush				7036 Conley St. Balto. Md. 21224					
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State	
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State				St. Stanislaus Cemetery				Baltimore, Maryland	
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
George A. Weber & Sons Inc.				George A. Weber & Sons Inc. 705 S. Ann St. Balto. Md. 21231					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
Metastatic Lung Cancer									
DUE TO (OR AS A CONSEQUENCE OF):									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?	
								1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
2 <input type="checkbox"/> Accident									
3 <input type="checkbox"/> Suicide									
4 <input type="checkbox"/> Homicide									
8 <input type="checkbox"/> Could not be determined									
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED					
29a. CERTIFIER (Check only one)				29b. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				009539				8/12/91	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. DATE SIGNED (Month, Day, Year)					
Larry Waterbury, M.D.				8/12/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE	
LARRY WATERBURY, M.D.				AUG 12 1991				Wilson-Randall	

01518 10

ITEMS:23,27 per ME  
G-679 9/6/91 cm

91-4519-510

91 21820

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First Middle, Last) <b>NIKIENNA RHODES</b>				2. DATE OF DEATH 08 MONTH 06 DAY 1991 YEAR		3. TIME OF DEATH 2:55 P M		
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>2 9</b>		7. DATE OF BIRTH (Month, Day, Year) <b>5-27-91</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY OF MARYLAND, M/S</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH		
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALT</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>1522 PRESTON ST</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>D</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>Michael Rhodes</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CHANTREL BRIDGEFORTH</b>				
19a. INFORMANT'S NAME (Type/Print) <b>CHANTREL BRIDGEFORTH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1522 PRESTON ST BALT MD 21213</b>				
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARbutus mem PC 8/12</b>		20c. LOCATION — City or Town, State <b>BALD. MD.</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bette's Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST 21213</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SUDDEN INFANT DEATH SYNDROME</b> Due to (or as a consequence of): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Paula L. ... MD</b>				29c. LICENSE NUMBER <b>OCME</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J. Loran Locke MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>								
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21821

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>MARY SHEA</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:48 AM</b>
4. SOCIAL SECURITY NUMBER <b>253206515</b>	5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>70</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 4, 1920</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Georgia</b>		9. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		
9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>City</b>		
RESIDENCE OF DECEASED				
10a. STATE <b>Md.</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>4202 Westview Road</b>		10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b>X</b>
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 6+) <input checked="" type="checkbox"/>		
16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>Shamrod Faircloth</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Victoria Marfield</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Neva Ezoll</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6121 Robbins Circle Jacksonville, Fla. 32211</b>		
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Hilltop Service Corp Aug. 12, 1991</b>		20c. LOCATION — City or Town, State <b>Towson, Md.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James J. Gladden</b>		22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>PNEUMONIA</b> Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Perforated Sigmoid</b> <b>Peritonitis</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>BP 20x, COPD, Hepes 20x</b>				Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)	28b. TIME OF INJURY M <input type="checkbox"/> 1 <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Resident</b>		29c. LICENSE NUMBER <b>040782</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BARRY KHURZ MD Good Samaritan Hospital</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51051



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21822	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Mary A. Sullivan				2. DATE OF DEATH MONTH 08 DAY 08 YEAR 91				3. TIME OF DEATH 2:45a	
4. SOCIAL SECURITY NUMBER 214-03-4904		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) 81 YRS.	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) July 23, 1910	
8. BIRTHPLACE (State or Foreign Country) Maryland				9a. FACILITY NAME (If not institution, give street and number) UNION MEMORIAL HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE City	
9c. COUNTY OF DEATH				10a. STATE Maryland				10b. COUNTY BALTIMORE	
10c. CITY, TOWN OR LOCATION BALTIMORE City				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER 6104 Loch Raven Blvd.				10f. ZIP CODE 21239				10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Waitress Ret.		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) Augustus Willback				18. MOTHER'S NAME (First, Middle, Maiden Surname) Genevieve Powers					
19a. INFORMANT'S NAME (Type/Print) Gregory P. Sullivan				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 972 Plank Road New Freedom, Penna. 17349					
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) Hilltop Service Corp. 8/9/91		20c. LOCATION — City or Town, State Towson Maryland					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Milton J. Knight Jr.				22. NAME AND ADDRESS OF FACILITY Baltimore, Md. 21214 Leonard J. Ruck, Inc. 5305 Harford Road					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Pneumonia DUE TO (OR AS A CONSEQUENCE OF): b. C. Difficile Enterocolitis DUE TO (OR AS A CONSEQUENCE OF): c. CHF DUE TO (OR AS A CONSEQUENCE OF): d. metastatic breast CA Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. anemia, renal insufficiency								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 5 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Frank R. Bohler DO				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/18/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Frank R. Bohler UNION MEMORIAL HOSP									
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE John H. ...					

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91-4518-510

91 21823

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Michael B. Suwall</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 06 1991</b>		3. TIME OF DEATH <b>1:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>213-38-7368</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>50</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-30-40</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>1016 E. Lake Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>n/a</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore City</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1016 E. Lake Ave.</b>	
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) <b>12 yrs.</b> College (1-4 or 5+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Self-employed</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Contractor</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Bernard Ferdinand Suwall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Katherine Simering</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernard F. Suwall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6120 Haddon Hall Rd. Baltimore, Maryland 21212</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Cemetery 8/7/91</b>			
20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John G. Reitz</b>			
22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home 6500 York Rd. Baltimore, Maryland 21212</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Intraoral Shotgun Wound</b>			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →				Approximate interval Between Onset and Death			
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST				DUE TO (OR AS A CONSEQUENCE OF):			
DUE TO (OR AS A CONSEQUENCE OF):				DUE TO (OR AS A CONSEQUENCE OF):			
DUE TO (OR AS A CONSEQUENCE OF):				DUE TO (OR AS A CONSEQUENCE OF):			
DUE TO (OR AS A CONSEQUENCE OF):				DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? X YES 2 <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year) <b>08 06 1991</b>				28b. TIME OF INJURY <b>12:57p</b>			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>Self Inflicted Wound</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>At home</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1016 E. Lake Avenue</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>John G. Reitz MD</b>			
29c. LICENSE NUMBER <b>O.C.M.E.</b>				29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John G. Reitz MD 111 Penn Street, Baltimore Maryland 21201</b>				31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>			
32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2

91 21824

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) ANNA MARY SCHAUM				2. DATE OF DEATH MONTH 08 DAY 09 YEAR 91		3. TIME OF DEATH 10:30A M	
4. SOCIAL SECURITY NUMBER 213-05-5537 218-22-0882		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 76 YRS.		7. DATE OF BIRTH (Month, Day, Year) 07/08/1915	
9a. FACILITY NAME (If not institution, give street and number) GREATER BALTIMORE MEDICAL CENTER				9b. CITY, TOWN OR LOCATION OF DEATH TOWSON		9c. COUNTY OF DEATH BALTIMORE	
10a. STATE MD				10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PARKVILLE	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 1352 DEANWOOD ROAD				10f. ZIP CODE 21234		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 10 Years College (1-4 or 5+)				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY Home	
17. FATHER'S NAME (First, Middle, Last) William Schutte				18. MOTHER'S NAME (First, Middle, Maiden Surname) Anna King			
19a. INFORMANT'S NAME (Type/Print) Daniel Schaum				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1352 Deanwood Rd. Baltimore, Md. 21234			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Dulaney Valley Memorial Gdns. 8/12 Timonium, Md.		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James F. Burnside, Jr.				22. NAME AND ADDRESS OF FACILITY Mitchell-Wiedefeld Home, Inc. 6500 York Rd. Baltimore, Md. 21212			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. GI BLEEDING DUE TO (OR AS A CONSEQUENCE OF):				Approximate interval Between Onset and Death 2 DAYS	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. RENAL FAILURE, UREMIA DUE TO (OR AS A CONSEQUENCE OF):				2 WEEKS	
		c. METASTATIC TRANSITIONAL CELL CA OF KIDNEY DUE TO (OR AS A CONSEQUENCE OF):				1 YEAR	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Ruth Kauter MD				29c. LICENSE NUMBER D28594		29d. DATE SIGNED (Month, Day, Year) 8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE Gina Davidson-Rendell			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-6820  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

01 51050

2

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been verified by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR STATE REGISTRAR ALBERT SIMPLER

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21825

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALBERT SIMPLER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>1950 M</b>			
4. SOCIAL SECURITY NUMBER <b>217-26-438</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-09-19</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>ST. AGNES HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>---</b>			
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1114 BAKER AVENUE</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (8-12)</b> <b>7th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MECHANIC</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AUTOMOBILE</b>							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
19a. INFORMANT'S NAME (Type/Print) <b>CAROLYN WRIGHT (DAUGHTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4 STAYMAN COURT CATONSVILLE, MD 21228 APT.H</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WOODLAWN CEMETERY</b>		20c. LOCATION — City or Town, State <b>WOODLAWN, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY M &amp; RUSSELL C WITZKE FUNERAL HOME</b> <b>1630 EDMONDSON AVENUE CATONSVILLE, MD 21228</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) →  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. <b>Massive hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Ruptured Abdominal Aortic Aneurysm</b> DUE TO (OR AS A CONSEQUENCE OF):  c. _____ DUE TO (OR AS A CONSEQUENCE OF):  d. _____								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary artery disease</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter Mattei</b>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter Mattei John Hopkins Hospital 600 N. Wolfe St. B. MD.</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>							

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20% COTTON FIBER

100% COTTON FIBER



91 21826

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) LAVINIA ELIZABETH SMITH				2. DATE OF DEATH MONTH DAY YEAR 08 09 1991		3. TIME OF DEATH 3:59 P M	
4. SOCIAL SECURITY NUMBER 142-36-5821		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 85 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-02-1906	
8. BIRTHPLACE (State or Foreign Country) PENNSYLVANIA				9a. FACILITY NAME (If not institution, give street and number) THE JOHNS HOPKINS HOSPITAL		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY	
9c. COUNTY OF DEATH BALTIMORE CITY				10a. STATE MARYLAND			
10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION BALTIMORE		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 715 MAIDEN CHOICE LANE, PARKVIEW "202"				10f. ZIP CODE 21228		10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMY FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4 yrs.		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) SCHOOL TEACHER		16b. KIND OF BUSINESS/INDUSTRY PA & NJ SCHOOL SYSTEMS			
17. FATHER'S NAME (First, Middle, Last) THOMAS WILLIAMS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ELIZABETH MILES			
19a. INFORMANT'S NAME (Type/Print) PETER P. SMITH				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 715 MAIDEN CHOICE LANE, PARKVIEW 202, BALTO, MD 21228			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DUNMORE CEMETERY		20c. DATE 8-13		20d. LOCATION — City or Town, State SCRANTON, PENNSYLVANIA	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Jackie H. Shannon</i>				22. NAME AND ADDRESS OF FACILITY HOWARD H. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD 21229			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>HEMORRHAGE</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>COAGULOPATHY</u> DUE TO (OR AS A CONSEQUENCE OF): c. <u>OPEN HEART SURGERY MITRAL &amp; AORTIC VALVE REPLACEMENT</u> DUE TO (OR AS A CONSEQUENCE OF): d. <u>MITRAL AND AORTIC STENOSIS</u> Approximate Interval Between Onset and Death 3 HR 3 HR 9 HR YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input checked="" type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>David L. Johnson</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID JOHNSON				The Johns Hopkins Hospital 600 N. WOLFE ST BALTO, MD 21245			
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial certificate. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51859

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1 - FOR  
STATE  
REGISTRAR

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** **REG. NO.**

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Anna Rose Strappelli</b>						2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:10a M</b>		
4. SOCIAL SECURITY NUMBER <b>217051998</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>95</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____		
7. DATE OF BIRTH (Month, Day, Year) <b>06 22 96</b>						8. BIRTHPLACE (State or Foreign Country) <b>Italy</b>				
9a. FACILITY NAME (If not institution, give street and number) <b>Church Home Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT										
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>704 South Potomac Street</b>						10f. ZIP CODE <b>21224</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR DR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machine Operator</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Continental Can Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Marion De Liberato</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Felicia</b>				
19a. INFORMANT'S NAME (Type/Print) <b>Ralph Strappelli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>704 Hanson Court Belair, Md. 21014</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery Balto., Md.</b>				20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles S. Zeiler</b>						22. NAME AND ADDRESS OF FACILITY <b>Charles S. Zeiler &amp; Son Inc. 901 S. Conkling St.</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF):								
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST {		b. <b>Anemia</b> DUE TO (OR AS A CONSEQUENCE OF):								
		c. <b>Urinary Tract Infection</b> DUE TO (OR AS A CONSEQUENCE OF):								
		d. _____								
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO										
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> ODA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)										
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Terran Eldermyr House Officer</b>						29c. LICENSE NUMBER <b>D38993</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/10/91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Terran Eldermyr 3630 Paskin Place Baltimore MD 21207</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>								

1

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21828			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
WILLIAM SCHMIDT				8 9 12-36 PM							
4. SOCIAL SECURITY NUMBER		5. SEX	8. AGE (In yrs. last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
212-01-0396		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	82 YRS.	MONTHS DAYS		HOURS MIN.		04/16/09		Maryland	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Harbor Hospital Center				Baltimore				Baltimore			
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
Maryland		Baltimore		Brooklyn				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
5247 Patrick Henry Drive				21225				USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?				14. RACE			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				American Indian, Black, White, etc.			
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:				Specify: White			
15. DECEDENT'S EDUCATION				16a. DECEDENT'S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUSTRY			
(Specify only highest grade completed)				(Give kind of work done during most of working life. Do NOT use retired.)							
Elementary/Secondary (0-12)				College (1-4 or 5+)				Stock clerk			
Painting mfg.											
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Henry Schmidt				Lilly M. Jones							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Agnes V. Schmidt				5247 Patrick Henry Drive Baltimore, Md. 21225							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION		20c. LOCATION							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		(Name of cemetery, crematory or other place)		City or Town, State							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Loudon Park Cemetery		Baltimore, Maryland							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
				Ambrose Funeral Home, Inc.							
				1328 Sulphur Spring Road 21227							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. ACUTE RESPIRATORY FAILURE											
DUE TO (OR AS A CONSEQUENCE OF):											
b. ACUTE PULMONARY EDEMA											
DUE TO (OR AS A CONSEQUENCE OF):											
c. REFRACTORY CONGESTIVE HEART FAILURE											
DUE TO (OR AS A CONSEQUENCE OF):											
d.											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA				OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation				(Month, Day, Year)		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
2 <input type="checkbox"/> Accident											
3 <input type="checkbox"/> Suicide											
4 <input type="checkbox"/> Homicide											
6 <input type="checkbox"/> Could not be determined											
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER							
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				Anthee Nwandu M.D. House Physician							
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
				A 92441614-24				8/9/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
ANTHEE NWANDU, 3001 S. HANOVER STREET, BALTIMORE MD 21230											
HARBOR HOSPITAL CENTER											
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
AUG 12 1991				Julia Davidson-Rendall							

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91 21829

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>CLINTON Hughes TERR Y</i>				2. DATE OF DEATH MONTH DAY YEAR <i>8 10 91</i>		3. TIME OF DEATH <i>7 35A</i>	
4. SOCIAL SECURITY NUMBER <i>230-32-8089</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>61</i> YRS.		7. DATE OF BIRTH Month Day, Year <i>NOV. 1, 1929</i>	
8a. FACILITY NAME (If not institution, give street and number) <i>Good Samaritan Hospital</i>				8b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		8c. BIRTHPLACE (State or Foreign Country) <i>Va.</i>	
10a. STATE <i>Md.</i>				10b. COUNTY <i>Baltimore</i>		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>4002 White Avenue</i>			
10f. ZIP CODE <i>21206</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>Korea &amp; Vietnam</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <i>X</i>		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12</i> College (1-4 or 5+) <i>College</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Ret. U.S. Navy</i>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>Walter Terry</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Susie Sessor</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Shirley J. Davenport</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1305 Longview Drive Woodbridge, Va. 22191</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Parkwood Aug. 13, 1991</i>		20c. LOCATION — City or Town, State <i>Baltimore, Md.</i>		20d. DATE <i>Aug. 13, 1991</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James J. Bladden</i>				22. NAME AND ADDRESS OF FACILITY <i>Leonard J. Ruck Inc. 5305 Harford Road 21214</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>INTRACTABLE CHF</i> a. DUE TO (OR AS A CONSEQUENCE OF): b. <i>CARDIOMYOPATHY</i> c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death <i>1 mo.</i> <i>87</i>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>W. Davidson</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>Aug 12 1991</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>5601 Loch Raven Blvd Baltimore MD 21237</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 12 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 21039

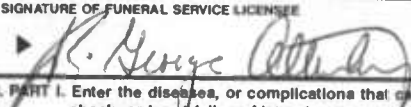

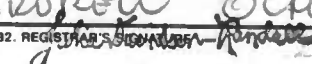


91-3982-043

91-1271 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21830

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM LEWIS TATE, JR.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>07 14 1991</b>		3. TIME OF DEATH <b>5:55 P M</b>					
4. SOCIAL SECURITY NUMBER <b>238-82-7000</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>38</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 17, 1952</b>		8. BIRTHPLACE (State or Foreign Country) <b>Washington, D.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>INTERSTATE #81</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>HAGERSTOWN</b>				9c. COUNTY OF DEATH <b>WASHINGTON</b>			
10a. STATE <b>Ohio</b>		10b. COUNTY <b>Franklin</b>		10c. CITY, TOWN OR LOCATION <b>Columbus</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1614 Greenway Ave.</b>				10f. ZIP CODE <b>43203</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Songwriter</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Self</b>						
17. FATHER'S NAME (First, Middle, Last) <b>William Lewis Tate, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn F. Shade</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Evelyn F. Smith</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1614 Greenway Ave., Columbus, OH 43203</b>							
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input checked="" type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Evergreen Burial Park</b>		DATE <b></b>		20c. LOCATION — City or Town, State <b>Columbus, OH</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Baltimore, MD 21214</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b></b> b. <b></b> c. <b></b> d. <b></b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b></b>								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) <b>INTERSTATE #81</b>							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input checked="" type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b></b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>07-15-1991</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>M. Koron A. Koron 11 Penn St Baltimore MD 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE 							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

08019-10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

1. FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21831

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM D TENLEY</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>				3. TIME OF DEATH <b>8:00A</b>					
4. SOCIAL SECURITY NUMBER <b>091 09 1330</b>				5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11 20 13</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>					
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1300 HIGHLAND DR</b>				10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Superintendent</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Md. Slag Co.</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Howard William Tenley</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Tiemann</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Ruth S. Tenley</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1300 Highland Dr. Baltimore, Maryland 21239</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood</b>		DATE <b>8-10</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Dennis Stephen Xenakis</i> <b>Dennis Stephen Xenakis</b>				22. NAME AND ADDRESS OF FACILITY <b>Mitchell-Wiedefeld Home</b> <b>6500 York Road Baltimore, Maryland 21212</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIOGENIC SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>PULMONARY EDEMA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF):										Approximate Interval Between Onset and Death <b>16 hrs</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		26. PLACE OF DEATH (Check only one) OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ronald W. Wendell</i>						29c. LICENSE NUMBER <b>D32338</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.7.91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>G.B.M.C. 6701 N CHARLES ST</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 12 1991</b>				32. REGISTRAR'S SIGNATURE <i>G. Davidson-Rendell</i>									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21832

1. DECEDENT'S NAME (First, Middle, Last) IRMA (JOHNSON) WAKE				2. DATE OF DEATH MONTH 08 DAY 08 YEAR 91		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 220-30-1145		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 79 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10-15-11		8. BIRTHPLACE (State or Foreign Country) MD			
9a. FACILITY NAME (If not institution, give street and number) 11 West 20th Street Apt.18J				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH			
10a. STATE MD			10b. COUNTY			10c. CITY, TOWN OR LOCATION BALTIMORE, MD			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER 11 W. 20th STREET APT. 18J				10f. ZIP CODE 21218			10g. CITIZEN OF WHAT COUNTRY? U.S.A.				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: Black				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12TH College (1-4 or 5+) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY SOCIAL SECURITY				
17. FATHER'S NAME (First, Middle, Last) ERNEST JOHNSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) IRENE FOSTER							
19a. INFORMANT'S NAME (Type/Print) CLARENCE WAKE				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 11 W. 20th ST. APT. 18J/ BALTIMORE, MD 21218							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) GARRISON FOREST VA CEM.			DATE		20c. LOCATION — City or Town, State OWINGS MILLS, MD				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Calvin L. Williams				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH F.H. 1101 E. North Ave.							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Acute Aortic Cardiac DUE TO (OR AS A CONSEQUENCE OF): b. HCUV DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER Theodore Patterson						29c. LICENSE NUMBER D09643		29d. DATE SIGNED (Month, Day, Year) 8/9/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) AUG 12 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>AHRENS, JOSEPH R.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-8-91</b>		3. TIME OF DEATH <b>6:58</b> M	
4. SOCIAL SECURITY NUMBER <b>216-10-5025</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-15-06</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>Fallston General Hospital 3304 Claydon Rd</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>Fallston</b>		8c. COUNTY OF DEATH <b>Harford</b>	
9a. STATE <b>Md.</b>		9b. COUNTY <b>Baltimore</b>		9c. CITY, TOWN OR LOCATION <b>Middle River</b>		9d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10a. STREET AND NUMBER <b>3536 Honeysuckle Lane</b>				10f. ZIP CODE <b>21220</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Ironworker</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Henry Ahrens</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Klaas</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Shirley Piazza</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4005 Jacintha Way Baltimore Md. 21236</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>Moreland Memorial 8/12/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Connelly Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>ConnellyFuneralHome300MAceAve. 21221</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. <u>Arteriosclerotic Cardiovascular Disease</u></b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. _____</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. _____</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Richard J. Colfer M.D.</b>				29c. LICENSE NUMBER <b>DO 1194</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RICHARD J. COLFER M.D. 2013 Tenth Church Rd Dorchester, MD 21034</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21834

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Joseph Antoniak</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>7</i> YEAR <i>91</i>		3. TIME OF DEATH <i>12:40 P M</i>	
4. SOCIAL SECURITY NUMBER <i>219-16-4964</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>82</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>11/21/08</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MD.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Francis Scott Key Medical Center</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore MD</i>	
9c. COUNTY OF DEATH							
RESIDENCE OF DECEDENT							
10a. STATE <i>MD.</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTIMORE</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>7950 BANK ST.</i>				10f. ZIP CODE <i>21224</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <i>NO</i>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>WHITE</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>16 YRS.</i> College (1-4 or 5+) <i>NO</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>SELF EMPLOYED</i>		16b. KIND OF BUSINESS/INDUSTRY <i>PACKAGED GOODS</i>	
17. FATHER'S NAME (First, Middle, Last) <i>JULIAN ANTONIAK</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>MARY SZAREK</i>			
19a. INFORMANT'S NAME (Type/Print) <i>DOROTHY NIZNIK</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>10079-6 WINDSTREAM DR 21044</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>HOLY ROSARY CEM.</i>		20c. LOCATION — City or Town, State <i>BALTIMORE MD.</i>		20d. <i>21224</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond L. Kucynowski</i>				22. NAME AND ADDRESS OF FACILITY <i>2525 FLEET ST. BALTIMORE MD 21224</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Congestive Heart Failure</i>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <i>Cardiomyopathy</i>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
				28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael Harper MD</i>				29c. LICENSE NUMBER <i>032387</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/13/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Michael Harper MD Francis Scott Key Medical Center, Balt. MD 21224</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

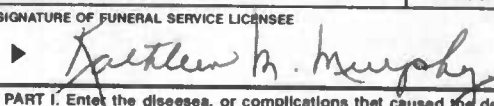
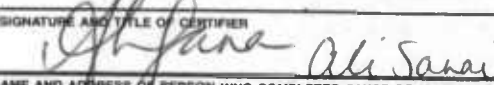
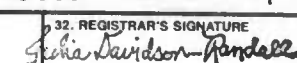
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Kevin M. ANTONELLI</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 8, 1991</b>		3. TIME OF DEATH HOURS MIN. SEC. <b>9:20 p m</b>	
4. SOCIAL SECURITY NUMBER <b>212-76-1398</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>March 2, 1957</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Balto., Md.</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore County</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Harford County</b>		10c. CITY, TOWN OR LOCATION <b>Abingdon</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER <b>313 Barclay Court</b>				10f. ZIP CODE <b>21009</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Vista Chemical Company</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Dominic R. Antonelli</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elizabeth Grace Gittings</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Carina M. Antonelli</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>313 Barclay Court, Abingdon, Maryland 21009</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith</b>		DATE <b>8/12</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc.</b> <b>6415 Belair Road, Baltimore, Maryland 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>Lymphoma</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Liver Failure</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>Fungal Meningitis</b> DUE TO (OR AS A CONSEQUENCE OF):							
d. _____							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER  <b>Ali Sanai</b>				29c. LICENSE NUMBER <b>N/A</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 8, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ali Sanai MD. 9000 Franklin Square Dr. Balto., Md. 21237</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marshall T. Bright Sr.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-44-2894 A</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/11/03</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Deaton Hosp. + Med. Cntr.</b>		9b. CITY, TOWN OR LOCATION OF DEATH	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3602 Copley Road</b>	
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/> <b>College 4</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mail Handler</b>		16b. KIND OF BUSINESS/INDUSTRY <b>U. S. Postal Service</b>	
17. FATHER'S NAME (First, Middle, Last) <b>James M. Bright</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Briscoe</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Emma G. Bright</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3602 Copley Road Baltimore, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Herbert E. Nutter</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Hypertensive nephropathy</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multifactorial dementia</b> <b>Prostate Cancer</b> <b>Osteomyelitis</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>George J. Baker MD</b>				29c. LICENSE NUMBER <b>D19858</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>George J. Baker, MD, 6115 S. Charles St. Baltimore, Md. 21230</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randell</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21201-0146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital for a physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached to use for a final-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY ELIZABETH BOYD				2. DATE OF DEATH MONTH 08 DAY 09 YEAR 91		3. TIME OF DEATH 11:45 am	
4. SOCIAL SECURITY NUMBER 218-16-3259		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 68 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan 30 1923	
8. BIRTHPLACE (State or Foreign Country) Virginia							
9a. FACILITY NAME (If not institution, give street and number) JOHNS HOPKINS HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY		9c. COUNTY OF DEATH BALTIMORE	
RESIDENCE OF DECEDENT							
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 305 East 22nd Street				10f. ZIP CODE 21218		10g. CITIZEN OF WHAT COUNTRY? U. S. A.	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (9-12) High School				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Domestic		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) Louis Moore				18. MOTHER'S NAME (First, Middle, Maiden Surname) Bessie Graves			
19a. INFORMANT'S NAME (Type/Print) Timothy Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 305 East 22nd St. Baltimore, MD 21218			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Western Star Cemetery		20c. LOCATION — City or Town, State Catonsville, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Herbert E. Nutter				22. NAME AND ADDRESS OF FACILITY Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Transfemoral Herniation</u> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <u>Subarachnoid hemorrhage</u> c. d. Approximate Interval Between Onset and Death ~ 12 hours ~ 12 hours							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Michael A. Williams, MD				29c. LICENSE NUMBER D40041		29d. DATE SIGNED (Month, Day, Year) August 9, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Neil C. Porter Johns Hopkins Hospital							
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE Gloria Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146  
 TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. After this certificate has been signed by the attending physician and completed in by the funeral director, it should be detached and filed in the hospital or funeral home. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21838	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Mary L. Butts				2. DATE OF DEATH MONTH DAY YEAR August 6, 1991				3. TIME OF DEATH 6:50 PM	
4. SOCIAL SECURITY NUMBER 214-26-1752		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11/21/1929		8. BIRTHPLACE (State or Foreign Country) BALTIMORE, MD.	
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2121 WINDSOR MILL ROAD				10f. ZIP CODE 21207				10g. CITIZEN OF WHAT COUNTRY? USA	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) VETTIE JACKSON				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADELINE JACKSON					
19a. INFORMANT'S NAME (Type/Print) VANESSA DOW				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4903 LINDSAY RD, BALTIMORE, MARYLAND 21229					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) WESTERN STAR CEMETERY		20c. LOCATION — City or Town, State CATONSVILLE, MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MARYLAND 21217					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <u>CARDIO PULMONARY ARREST</u> b. <u>ASPIRATION PNEUMONIA</u> c. <u>CHRONIC RENAL FAILURE, on Peritoneal Dialysis</u> d. <u>DISSEMINATED ARTERIOSCLEROSIS</u>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>THORACOTOMY OF FEM-FEM AND LEFT FEM POP BYPASS GRAFT AND LEFT ABOVE THE KNEE AMPUTATION</u> <u>THORACOTOMY OF RIGHT AXILLOFEMORAL BYPASS GRAFT AND RIGHT FEM POP BYPASS GRAFT</u>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER D19867				29d. DATE SIGNED (Month, Day, Year) 8/6/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) GARTH A.S. SAMUELS 6911 PARK HEIGHTS AVE BALTIMORE MD 21215									
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

02-1 80

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21839

1. DECEDENT'S NAME (First, Middle, Last) <u>BROWN DOROTHY MAE BROWN</u>				2. DATE OF DEATH MONTH <u>9</u> DAY <u>7</u> YEAR <u>1991</u>		3. TIME OF DEATH <u>6:10 PM</u>		
4. SOCIAL SECURITY NUMBER <u>218-18-3580</u>		5. SEX <u>M</u> <input type="checkbox"/> <u>F</u> <input checked="" type="checkbox"/>		6. AGE (In yrs. last birthday) <u>68</u> YRS.		7. DATE OF BIRTH (Month, Day, Year) <u>02/9/1923</u>		
8. BIRTHPLACE (State or Foreign Country) <u>BALTIMORE, MD</u>								
9a. FACILITY NAME (If not institution, give street and number) <u>UNIVERSITY HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>		9c. COUNTY OF DEATH		
RESIDENCE OF DECEDENT								
10a. STATE <u>MARYLAND</u>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <u>1010 W. BALTIMORE STREET, APT 502</u>				10f. ZIP CODE <u>21223</u>		10g. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <u>BLACK</u>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <u>PETER FRANKLIN</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>EMMA HARRIS</u>				
19a. INFORMANT'S NAME (Type/Print) <u>IRVIN JEROME BROWN</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>2506 W. FAIRMOUNT AVE, BALTIMORE, MD. 21229</u>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARRISON FORSET CEMETERY 8/13/91</u>		20c. LOCATION — City or Town, State <u>OWINGS MILL, MD</u>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</u>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { <u>Respiratory Arrest</u> DUE TO (OR AS A CONSEQUENCE OF): <u>COPD</u> DUE TO (OR AS A CONSEQUENCE OF):  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Sepsis</u> <u>Renal Failure</u>							Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <u>8-7-91</u>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>F DeLeon 22 S. Greene St., Baltimore MD 21201</u>								
31. DATE FILED (Month, Day, Year) <u>AUG 13 1991</u>				32. REGISTRAR'S SIGNATURE <u>[Signature]</u>				

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REG. NO.

**DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146**

DHMH-18 Rev. 1/89

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH		REG. NO.		
1. DECEDENT'S NAME (First, Middle, Last) <b>Anna M. Buckmaster</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 6, 1991</b>		3. TIME OF DEATH HOURS MIN. SEC. <b>6:35 P M</b>				
4. SOCIAL SECURITY NUMBER <b>218-07-2609</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-18-1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>7915 Colchester Court</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Pasadena</b>			9c. COUNTY OF DEATH <b>Anne Arundel</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Pasadena</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7915 Colchester Court</b>				10f. ZIP CODE <b>21122</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>--</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Domestic</b>			
17. FATHER'S NAME (First, Middle, Last) <b>John Leahy</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Violet Mc Manus</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Paul K. Buckmaster, Sr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7915 Colchester Court Pasadena, Md. 21122</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 8/8/91</b>			20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Stephen J. Thompson</i>				22. NAME AND ADDRESS OF FACILITY <b>McCully Funeral Home of Pasadena 3204 Mountain Rd., Pasadena, MD 21122</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiopulmonary arrest.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):									Approximate interval between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark Kaplan MD.</i>				29c. LICENSE NUMBER <b>022110</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Marc Kaplan 2845 Oakwood Rd. #200 Glen Burnie MD 21061</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>								

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 21842

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Marguerite Burruss</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>578-20-5948</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>75</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>7/ /16</b>		8. BIRTHPLACE (State or Foreign Country) <b>7/DC</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Prince Georges Community</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cheverly</b>		9c. COUNTY OF DEATH <b>PG</b>	
10a. STATE <b>Md</b>		10b. COUNTY <b>PG</b>		10c. CITY, TOWN OR LOCATION <b>Forestville</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7301 Cross St</b>				10f. ZIP CODE <b>20747</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Yrs</b> College (1-4 or 5+) <b>None</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HouseWife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Lawrence N Turner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary B Bell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Alice Burruss</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Same as 10a,b,c,d,e,&amp;f</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Ft Lincoln</b>		20c. LOCATION — City or Town, State <b>8/16/91 Brentwood, Md</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Juan Smith</b>				22. NAME AND ADDRESS OF FACILITY <b>John T Rhines Co., Inc 3015 12th St NE, DC 20017</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>Dementia</b> DUE TO (OR AS A CONSEQUENCE OF):  d.  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multiple Decubitus Ulcers</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>S. Trifoglio</b>				29c. LICENSE NUMBER <b>D32934</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>S. Trifoglio MD 7500 Greenway Ctr Drive Greenbelt MD 20770</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SP012 01

91 21843

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STANLEY BRAXTON</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>21</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>220 76 0164</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/4/57</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Whitestone, VA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Seaton Manor</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4800 Seaton Dr.</b>				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Full Time Student</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Braxton</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Iris Wood</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Iris Braxton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1208 Cherry Hill RD. apt. B 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Cedar Hill</b>		20c. LOCATION — City or Town, State <b>Baltimore</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vaughn C. Greene</b>		22. NAME AND ADDRESS OF FACILITY <b>James M. Morton FH/101 Laurens St</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MYCOBACTERIUM AVIUM INTRACELLULOSIS</b>							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. <b>AIDS</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael S. Knight, MD</b>				29c. LICENSE NUMBER <b>002290</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Rendall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The information on the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WALTER BRISCOE</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>6</b> YEAR <b>91</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>212-16-0212</b>		5. SEX <b>1</b> M <b>2</b> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-17-1917</b>	
8. BIRTHPLACE (State or Foreign Country) <b>ARUNDEL CO.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>BON SECOUR</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD.</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			
10d. INSIDE CITY LIMITS? <b>1</b> YES <b>2</b> NO				10e. STREET AND NUMBER <b>2450 WEST BALTIMORE ST.</b>			
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
11. MARITAL STATUS <b>1</b> Never Married <b>2</b> Married <b>3</b> Widowed <b>4</b> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> YES <b>2</b> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> YES <b>2</b> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>SANITATION WORKER</b>		16b. KIND OF BUSINESS/INDUSTRY <b>SANITATION DEPARTMENT</b>			
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOTTIE MACEY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LOTTIE MACEY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2450 WEST BALTO. ST., BALTO. MD., 21223</b>			
20a. METHOD OF DISPOSITION <b>1</b> Burial <b>2</b> Cremation <b>3</b> Removal from State <b>4</b> Donation <b>5</b> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>CEDAR HILL</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE, MD.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charlene P. Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 4433 1913 W. BALTO. ST. BALTO. MD., 21223 P.O. BOX</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <b>CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CORONARY ARTERY DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):							
c. <b>CHRONIC BRONCHITIS</b> DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> YES <b>2</b> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> YES <b>2</b> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> YES <b>2</b> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> Inpatient <b>2</b> Outpatient <b>3</b> DOA OTHER: <b>4</b> Nursing Home <b>5</b> Residence <b>6</b> Other (Specify)					
27. MANNER OF DEATH <b>1</b> Natural <b>2</b> Accident <b>3</b> Suicide <b>4</b> Homicide <b>5</b> Pending Investigation <b>6</b> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> YES <b>2</b> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <b>1</b> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature]</b>				29c. LICENSE NUMBER <b>027838</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/29/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOHN S HAYES, 70518 CAMP AVE, BALTIMORE, MD 21290</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

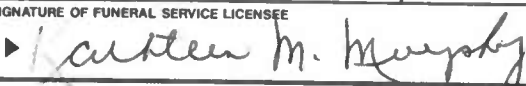
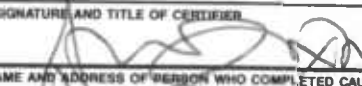
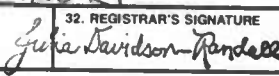
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1 -  
FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>J Dennis Berman</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 09 1991</b>		3. TIME OF DEATH <b>8:23 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-78-3622</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>18</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-30-1972</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Route 50, west of Hall Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Whaleysville</b>		9c. COUNTY OF DEATH <b>Worcester</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1101 Saint Paul Street, Unit 2001</b>			
10f. ZIP CODE <b>21202</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>11th Grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Pizza Hut</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Thomas Charles Berman</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Janis Elaine Flock</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thomas C. Berman</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1101 St. Paul Street, Unit 2001, Balto., Md. 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial</b>		DATE <b>8/14</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Head injury</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>On street</b>			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>08 09 1991</b>		28b. TIME OF INJURY <b>8:23 P M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Passenger in auto/tree impact</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>On street</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>Rte. 50(W) of Hall Road</b>		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 10 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Anna Dixon 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EMMA J. Cockrell</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1230 P M</b>	
4. SOCIAL SECURITY NUMBER <b>220-20-6854</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Apr 22 1927</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Mercy Medical Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH							
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3637 Forest Hill Road</b>				10f. ZIP CODE <b>21207</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>School Teacher</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Balto City School Sys</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Willie Richardson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Charles Cockrell</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3637 Forest Hill Rd Baltimore, MD 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD Veteran Cem/Garrison</b>		DATE		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vernon R Bailey</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Colon Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Renal Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Asthma</b> DUE TO (OR AS A CONSEQUENCE OF): d. <b>Hepatic Failure</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>2 years</b> <b>1 week</b> <b>years</b> <b>2 weeks</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE NOW INJURY OCCURRED			
				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Susan K. Shiber MD</b>				29c. LICENSE NUMBER <b>intern</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) - <b>ROOSEVELT CHARLIE CYRUS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>06</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7</b> <b>P</b> M	
4. SOCIAL SECURITY NUMBER <b>219-29-5880</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec 3 1932</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Veteran's Admin Hosp/Loch Raven</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>Baltimore</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4616 Manordene Rd Apt A-1</b>			
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korean Conflict</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th Grade</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Crane Operator</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel Corp.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Robbie Charlie Cyrus</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy O. Mahoney</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Cyrus</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>418 North Athol Ave Apt B Balto, MD 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park</b>		20c. LOCATION — City or Town, State <b>Baltimore Co., MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ernest R. Ferry, Jr.</i>		22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes, 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Endstage Hepatic Failure</b> Sequitally ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Alcohol Abuse</b> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Aspiration Disseminated Intravascular Coagulation</b>							Approximate Interval Between Onset and Death
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Boe Bright</i> <b>0486</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>22 S Green Street</b>							
31. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>		32. REGISTRAR'S SIGNATURE <i>June Davidson-Hendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH	
LANTHA Ross Clark				08 10 91				5:04 P M	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (In yrs. last birthday)	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
195-34-1256 A		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	73 YRS.	01/10/18		Alabama			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
Saint Agnes Hospital				Baltimore					
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
Maryland				Catonsville				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
5 Cargil Avenue				21228		U. S. A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		Specify: Black			
3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:					
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) College (1-4 or 5+)		School Teacher		Balto City Public School					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Louis B. Ross				Cara Bell					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
Donna Bohannon				1224 Weddwl Avenue Baltimore, MD 21227					
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		Crest Lawn Cemetery		Howard County, MD					
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY							
H. E. Nutter		Nutter Funeral Homes							
		2501 Gwynns Falls Parkway							
		Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →								Days	
a. ACUTE MYOCARDIAL INFARCTION									
DUE TO (OR AS A CONSEQUENCE OF):									
b. MYOCARDIAL ARRHYTHMIAS								Years	
DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?	
DIABETES MELLITUS WITH HYPEROSMOLAR COMA								1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
(Glucose 900)								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER						29c. LICENSE NUMBER	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		Jean M. Colandrea, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore MD 21229						29d. DATE SIGNED (Month, Day, Year)	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								D30802	
								► 08/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)		31. DATE FILED (Month, Day, Year)						32. REGISTRAR'S SIGNATURE	
Jean M. Colandrea, M.D., St. Agnes Hospital, 900 Caton Ave., Baltimore MD 21229		AUG 13 1991						Julia Davidson-Randall	

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>RONALD DELEAF CLEMSEN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:50</b> a.m.	
4. SOCIAL SECURITY NUMBER <b>219-32-8395</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>54</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-16-36</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8703 Valleyfield Rd.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Lutherville</b>	
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Lutherville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8703 Valleyfield Rd.</b>	
10f. ZIP CODE <b>21093</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 yrs</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>System Analyst</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Milton Clemesen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jennie Mastracci</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helen Ann Clemesen</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8703 Valleyfield Rd. Lutherville, Md. 21093</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley</b>		DATE <b>8-12</b>		20c. LOCATION — City or Town, State <b>Timonium, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Ther A. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>Ruck Towson Funeral Home, Inc. 1050 York Rd. Towson, Md. 21204</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>EXTENSIVE METASTATIC LIVER CANCER</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>CANCER OF THE COLON</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Emil Kfoury M.D.</i>				29c. LICENSE NUMBER <b>006392</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-9-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Emil Kfoury M.D. 617 E. Stemmers Run</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





91 21850

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EARL CHAPMAN</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>077-52-5229</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>29</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/19/62</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>2428 CALLOW AVENUE</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>		8c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>NY</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BROOKLYN</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1786 PROSPECT PL. APT. 11E</b>				10f. ZIP CODE <b>11233</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12TH</b> Elementary/Secondary (9-12) <b>College</b> (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>CONSTRUCTION WORKER</b>	
17. FATHER'S NAME (First, Middle, Last) <b>EARL LOUREE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIRGINIA MURPHY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VIRGINIA CHAPMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1786 PROSPECT PLACE /BROOKLYN, NY 11233</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ROSE HILL CEMETERY</b>		20c. LOCATION — City or Town, State <b>LINDER UNION, N.J.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. /1101 E.NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACUTE LYMPHOCYTIC LEUKEMIA (ALL)</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>WG NELSON MD</b>				29c. LICENSE NUMBER <b>D39683</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>WILLIAM G. NELSON MDPH Johns Hopkins Oncology Center BALTIMORE MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 11820

91 21851

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Dorothy Crosby Doroyhy G. Crosby (Grinnell)</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>1</i> YEAR <i>91</i>		3. TIME OF DEATH <i>1840</i> M	
4. SOCIAL SECURITY NUMBER <i>27-30-1570</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		8. AGE (In yrs. last birthday) <i>78</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>04 10 18</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>University of Maryland</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>		9c. COUNTY OF DEATH <i>Dachman</i>	
10a. STATE <i>MD</i>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <i>851 GORGE ST</i>		10f. ZIP CODE <i>21201</i>	
10g. CITIZEN OF WHAT COUNTRY?				11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Afr. American</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Lonnie Birch</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Naomi Burch</i>			
19a. INFORMANT'S NAME (Type/Print) <i>John Rivers</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>851 George St. Balto. Md. 21201 Apt. (8C)</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Western Star</i>		20c. LOCATION — City or Town, State <i>Catonsville, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carol A. Estep</i>				22. NAME AND ADDRESS OF FACILITY <i>Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>metastatic cancer</i>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF):  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Eric Q. m</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>8/1/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>University of Maryland Baltimore, MD</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene for registration, removal, cremation, or burial.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours and returned with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH M			
Charles Perry Chetwood				Aug. 10 1991							
4. SOCIAL SECURITY NUMBER 422-34-5003		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 61 YRS.		7. DATE OF BIRTH (Month, Day, Year) Jan. 19 1930		8. BIRTHPLACE (State or Foreign Country) Alabama			
9a. FACILITY NAME (If not institution, give street and number) 20 Kitzbuhel Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Parkton				9c. COUNTY OF DEATH Baltimore			
RESIDENCE OF DECEDENT											
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Parkton		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 20 Kitzbuhel Rd.				10f. ZIP CODE 21120		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES Korea		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) 4				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Branch Mgr. of Production Coca Cola USA				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S Name William Perry Chetwood				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ellen Juanita Russell							
19a. INFORMANT'S NAME (Type/Print) Mary Chetwood				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 20 Kitzbuhel Rd., Parkton, Md. 21120							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Elmwood Cemetery		DATE		20c. LOCATION — City or Town, State Birmingham, Alabama					
21. SIGNATURE OF FUNERAL SERVICE/LICENSEE Bryan W. Clary				22. NAME AND ADDRESS OF FACILITY Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd., Timonium, Md. 21093							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Sudden Cardiac Death DUE TO (OR AS A CONSEQUENCE OF): b. Cardiomyopathy DUE TO (OR AS A CONSEQUENCE OF): c. Multiple Myeloma DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death 1 yr 8 yrs			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Ruth Kantor				29c. LICENSE NUMBER D28594		29d. DATE SIGNED (Month, Day, Year) 8/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Ruth Kantor, M.D. Physicians Pavilion, Suite 614 G.B.M.C., Towson, Md.				31. DATE AUG 13 1991				32. REGISTRAR'S SIGNATURE Jana Davidson-Hendall			

01 51025

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Hon Van Chau</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:42 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>586-09-5938</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>52</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jan. 1 1939</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>313 LORD BYRON LANE #T-1</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Cockeysville</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Cockeysville</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>313 Lord Byron Lane - T1</b>				10f. ZIP CODE <b>21030</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Vietnam</b>	
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Quan Minh Chau</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Trang Thi Lam</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Linh To Nong</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>313 Lord Byron Lane T1, Cockeysville, Md. 21030</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input type="checkbox"/> Burial <b>2</b> <input checked="" type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Bryan W. Clary</i> <b>Bryan W. Clary</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Maryland 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Arteriosclerotic cardiovascular disease</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>7</b> <input type="checkbox"/> Homicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>A.M. Dixon</i> <b>A.M. Dixon</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/11/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>Jane Davidson-Bondell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51823



ITEM:23 per ME  
G-680 10/15/91 cm  
ITEMS:23pt1,pt2,27 per ME  
G-679 9/20/91 cm  
91-4547-510

91 21854

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James A. Chambers</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>9:35 P M</b>			
4. SOCIAL SECURITY NUMBER <b>215-40-9538</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/14/44</b>			
8. BIRTHPLACE (State or Foreign Country) <b>Baltimore</b>		9a. FACILITY NAME (If not institution, give street and number) <b>2554 Francis Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			
9c. COUNTY OF DEATH <b>Baltimore</b>				10a. STATE <b>MD</b>					
10b. COUNTY <b>MD</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>					
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>2554 Frances St.</b>					
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Mover</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Mayflower</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Chambers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Helen Chiles</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Elizabeth Chiles</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2554 Frances St.</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Calvary</b>		DATE <b>8/13/91</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>James A. Morton</b>				22. NAME AND ADDRESS OF FACILITY <b>James A. Morton &amp; Sons 1701 Laurens St.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>MITRAL VALVE PROLAPSE</b> <b>HYPERTENSIVE CARDIOMYOPATHY</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>ARTERIAL HYPERTENSION</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIAL HYPERTENSION</b>						24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO									
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 09 1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>									
31. DATE Filled (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>					

1944-1945

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>LILLIAN MARY CARR</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:31 AM</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-25-10</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>ST Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>900 Caton Ave</b>		9c. COUNTY OF DEATH <b>Maryland</b>	
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3330 Wilkens Avenue</b>				10f. ZIP CODE <b>Caton Manor</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (14 or 5+) <input type="checkbox"/>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>William Thompson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Martha Perkins</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Lillian Jacison</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2830 Potee Street Balto., MD. 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MT. Zion Cem.</b>		20c. LOCATION — City or Town, State <b>Balto., MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dorothy Hector</b>		#281		22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe St Balto., MD 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac Arrest</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. <b>Resp. failure</b> b. <b>Renal failure</b> c. <b>Stroke</b> d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>John Culeano MD</b>				29c. LICENSE NUMBER <b>D3938</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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COPIES

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21856					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) Juliana M. Croubels				2. DATE OF DEATH MONTH DAY YEAR 8-9-1991				3. TIME OF DEATH 10 <sup>50</sup> P M					
4. SOCIAL SECURITY NUMBER 272-22-8104		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 12-3-1902		8. BIRTHPLACE (State or Foreign Country) Belguim	
9a. FACILITY NAME (If not institution, give street and number) Bel Forest Nursing Home				9b. CITY, TOWN OR LOCATION OF DEATH Fallston				9c. COUNTY OF DEATH Harford					
RESIDENCE OF DECEDENT													
10a. STATE Md.		10b. COUNTY Harford		10c. CITY, TOWN OR LOCATION Fallston				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 1408 Terry Way				10f. ZIP CODE 21047				10g. CITIZEN OF WHAT COUNTRY? U.S.A.					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+) Unknown		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Seamstress		16b. KIND OF BUSINESS/INDUSTRY Canvas Co.									
17. FATHER'S NAME (First, Middle, Last) Karolus Ludovicus				18. MOTHER'S NAME (First, Middle, Maiden Surname) Marie Elodie Callewaert									
19a. INFORMANT'S NAME (Type/Print) Mrs. Jeannette Johnson				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10621 N.W. 18th St. Plantation, Fla. 33322									
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Greenmount Crematory		DATE		20c. LOCATION — City or Town, State Balto... Md.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Jay S. Miskin				22. NAME AND ADDRESS OF FACILITY Hartley Miller Funeral Home 7527 7527 Harford Rd. Balto... Md. 21234									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>respiratory arrest</u> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. CVA's P.V.D. ASCVD								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED					
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER David S. Dunn				29c. LICENSE NUMBER D32255		29d. DATE SIGNED (Month, Day, Year) 8/10/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DAVID S. DUNN													
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell									

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91-4526-510

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DEARIN CRAWLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 07 1991</b>		3. TIME OF DEATH <b>3:34 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-74-4642</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>31 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>2-3-1960</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1558 WINFORD ROAD</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>FRANK WHITE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LERAY SMITH</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LERAY BALL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1558 WINFORD ROAD BALTO. MD., 21239</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARETUS 8-13-91 ARETUS, MD.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles D. Brown</i>		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTO. ST., BALTO. MD., 21223 P.O. BOX 4433</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Multiple Gunshot wounds</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>08 07 1991</b>		28b. TIME OF INJURY <b>2:40 A M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>on street</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>1 blk. (N) Vincent Street</b>							
29. CERTIFIER (Check only) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29a. SIGNATURE AND TITLE OF CERTIFIER <i>John Davidson-Randall MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 07 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charon Locke MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate is to be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01-51921



REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

DMMH-16 Rev 1/89

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lillian Helen Dmec</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 11, 1991</b>		3. TIME OF DEATH YEAR <b>4:00 P. M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-03-6168</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Dec. 14, 1909</b>	
8. FACILITY NAME (If not institution, give street and number) <b>12139 Eastern Avenue</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		10. COUNTY OF DEATH <b>Baltimore</b>	
11. STATE <b>Md.</b>				12. COUNTY <b>Baltimore</b>		13. CITY, TOWN OR LOCATION <b>Baltimore</b>	
14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				15. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
16. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced				17. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>X</b>			
18. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>X</b>				19. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
20. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12) 6</b>				21. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>			
22. KIND OF BUSINESS/INDUSTRY							
23. FATHER'S NAME (First, Middle, Last) <b>Joseph Urban</b>				24. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Radej</b>			
25. INFORMANT'S NAME (Type/Print) <b>Paula J. Dmec-Thompson</b>				26. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12139 Eastern Avenue Baltimore, Md. 21220</b>			
27. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				28. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) DATE <b>Hilltop Service Corp. Aug 15, 1991</b>			
29. LOCATION — City or Town, State <b>Towson, Md.</b>							
30. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Paul L. Hartsock, Jr.</b>				31. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck Inc. 5305 Harford Road 21214</b>			
32. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEART ATTACK</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Angina, Diabetes mellitus</b> SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Diabetes</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b>							
33. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				34. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
35. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				36. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
37. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				38. DATE OF INJURY (Month, Day, Year) <b>Aug 11, 1991</b>			
39. TIME OF INJURY <b>M</b>				40. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
41. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				42. DESCRIBE HOW INJURY OCCURRED			
43. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
44. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
45. SIGNATURE AND TITLE OF CERTIFIER <b>Don Dmeco MD</b>				46. LICENSE NUMBER <b>509631</b>		47. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
48. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
49. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				50. REGISTRAR'S SIGNATURE <b>John F. ...</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.


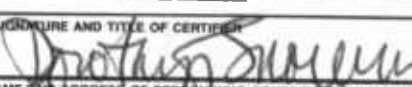
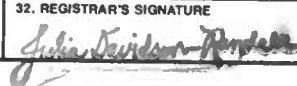
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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>G. BATTISTA EMILIO DAFORNO</b>				2. DATE OF DEATH MONTH <b>AUG.</b> DAY <b>11,</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>8:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>011-28-7481</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 7, 1936</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>FRANCIS SCOTT KEY</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8c. COUNTY OF DEATH <b>---</b>	
9. RESIDENCE OF DECEDENT				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8710 BLAIRWOOD</b>	
10f. ZIP CODE <b>21236</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>PEACETIME</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>NA</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED</b>		18b. KIND OF BUSINESS/INDUSTRY <b>---</b>			
17. FATHER'S NAME (First, Middle, Last) <b>VIRGLIS DAFORNO</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ANNA CESCUTTI</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CAROL ANN DAFORNO (WIFE)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8710 BLAIRWOOD, BALTIMORE, MD. 21236</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, etc., and date) <b>GARRISON FOREST CEMETERY</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE 	
22. NAME AND ADDRESS OF FACILITY <b>SCHIMUNEK FUNERAL HOMES, INC.</b> <b>9705 BELAIR ROAD, BALTIMORE, MD. 21236</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cancer of the throat</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input checked="" type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 					
29c. LICENSE NUMBER <b>D24149</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Dorothy Show, Loch Raven V. A. Hospital, 3900 Loch Raven Blvd., Balto, Md.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020  
TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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ITEM:4 per FH  
G-679 9/4/91 cm

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FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM DAY Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10 1991</b>		3. TIME OF DEATH <b>3:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-10-4841</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5-18-09</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glen Burnie</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>Box 604 Rt 2 Margate Drive</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>W.W. 2</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>Grade - 12</b> College (1-4 or 5+) <b>None</b>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Crane Operator</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Industry</b>	
17. FATHER'S NAME (First, Middle, Last) <b>William Day Sr.</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>James Day</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2531 Beckleysville Road, Freeland MD 21053</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven Mem. Park 08-14-91</b>		20c. LOCATION — City or Town, State <b>Glen Burnie, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Robert Gregory Behm</b>				22. NAME AND ADDRESS OF FACILITY <b>Kirkley Funeral Home 421 Crain Hwy. S.E. Glen Burnie, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Congestive heart failure (CHF)</b>						Approximate Interval Between Onset and Death	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28d. DESCRIBE HOW INJURY OCCURRED			
28b. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>YES # HOUSE-STAFF PHYSICIAN (HARBOR HOSPITAL CENTER)</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>Aug 10, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ALBERT ANGE VILLAROSA, 300 S. HANOVER ST, BALTIMORE, MD 21230</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

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TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21862							
CERTIFICATE OF DEATH				REG. NO.											
1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES F. DUNNIGAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 11, 1991</b>				3. TIME OF DEATH <b>11:52 P M</b>							
4. SOCIAL SECURITY NUMBER <b>218-14-9993</b>		5. SEX <b>1 X M 2 F</b>		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-11-1911</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>FRANKLIN SQUARE HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>ROSSVILLE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>DUNDALK</b>				10d. INSIDE CITY LIMITS <b>1 X YES 2 NO</b>							
10e. STREET AND NUMBER <b>7420 SCHOOL LANE</b>				10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>							
11. MARITAL STATUS <b>1 Never Married 2 X Married 3 Widowed 4 Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 X YES 2 NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 YES 2 X NO</b> Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 10TH GRADE</b> <b>College (14 or 5+) N/A</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>POST OFFICE - FEDERAL GOVERNMENT</b>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>HERMAN DUNNIGAN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ROSE REYNOLDS</b>											
19a. INFORMANT'S NAME (Type/Print) <b>MARY M. DUNNIGAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7420 SCHOOL LANE BALTIMORE, MARYLAND 21222</b>											
20a. METHOD OF DISPOSITION <b>1 X Burial 2 Cremation 3 Removal from State 4 Donation 5 Other (Specify)</b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>GARDENS OF FAITH CEM. 8-14-91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE MARYLAND</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Chad W. Fisher</i>				22. NAME AND ADDRESS OF FACILITY <b>DUDA-RUCK FUNERAL HOME OF DUNDALK INC. 7922 WISE AVENUE DUNDALK MD 21222</b>											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Probable Pulmonary Embolus</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Bronchiectasis</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. Chronic Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST												Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <b>1 YES 2 X NO</b>		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 YES 2 NO</b>	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1 YES 2 X NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 X Inpatient 2 ER/Outpatient 3 DOA</b> OTHER: <b>4 Nursing Home 5 Residence 8 Other (Specify)</b>											
27. MANNER OF DEATH <b>1 X Natural 2 Accident 3 Suicide 4 Homicide 5 Pending Investigation 8 Could not be determined</b>				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1 YES 2 NO</b>		28d. DESCRIBE NOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <b>1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b> <b>2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Aaron Green</i>				29c. LICENSE NUMBER <b>N/A</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Aaron Green MD. 9000 Franklin Square Drive 21237</b>															
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Lia Davidson-Randall</i>											

at 51005

91 21863

91-4608-510  
FOR  
1 - STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Rosetta Wooden Epps</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1247 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217-12-0170</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-14-14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1315 WINSTON AVENUE</b>	
10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4TH</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEKEEPER</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>MACK KILLEBREW</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>HATTIE HARDY</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WALTER KILLEBREW</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>918 E. 41st STREET/BALTIMORE, MD 21218</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD NAT MEM. PARK CEM.</b>		20c. LOCATION — City or Town, State <b>LAUREL, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glady Warden</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b>							
Due to (or as a consequence of):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
Due to (or as a consequence of):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension, Renal Insufficiency</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G Wright MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 12 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G Wright MD DCME 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 51883

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use in the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21864

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR J GLADDEN, III</b>				2. DATE OF DEATH MONTH <b>6</b> DAY <b>8</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>4:28 A.M.</b>					
4. SOCIAL SECURITY NUMBER <b>216-32-1851</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Jun 24 1938</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Union Memorial Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>			9c. COUNTY OF DEATH				
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>1041 Marlau Drive</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>			16b. KIND OF BUSINESS/INDUSTRY				
17. FATHER'S NAME (First, Middle, Last) <b>Arthur J. Gladden, II</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dorothy Barnes</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Rosanna Gladden</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1041 Marlau Drive Baltimore, MD 21212</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>New Cathedral Cemetery 8/10 Baltimore, Maryland</b>		DATE		20c. LOCATION — City or Town, State					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vernon R. Beuley</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Cerebrovascular Accident</b> <b>b. Atherosclerosis</b> <b>c. INSULIN DEPENDENT DIABETES</b> <b>d. HYPERTENSION</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>h. Renal insufficiency - mild</b>								Approximate Interval Between Onset and Death <b>1 hour</b> <b>years</b> <b>years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hypertension</b> <b>hyperlipidemia</b> <b>Renal insufficiency - mild</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] M.D.</b>		29c. LICENSE NUMBER <b>D35695</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-6-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>N. ERIC CORNELL, M.D. 716 Marden Chase Ln S-206 Balt. 21228</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

21 51824

91 21865

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM C. GARNETT</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08-11-91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>219-01-1114</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-09-15</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>3328 ELMLEY AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>		9c. COUNTY OF DEATH <b>MD.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3328 ELMLEY AVENUE</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6th</b> College (1-4 or 5+) <b>DISABLED</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN GARNETT</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LILLIAN COLEMAN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>WELHELMEMIA GARNETT</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3328 ELMLEY AVE./BALTIMORE, MD. 21213</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Glady Waned</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. /1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Hepatoma</b>							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ICR/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Jim MD J2051</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAVID LIM, Johns Hopkins Hosp, Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 5100



91-4218-510

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21866

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>James Edward Glasco</b>				2. DATE OF DEATH MONTH <b>07</b> DAY <b>24</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>12:18 AM</b>	
4. SOCIAL SECURITY NUMBER <b>218-42-4169</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/24/45</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7204 Jimrowe Ct.</b>		10f. ZIP CODE <b>21237</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Afr. American</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>?</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Esther Glasco</b>				19a. INFORMANT'S NAME (Type/Print) <b>Jacqueline Holland</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7204 Jimrowe Ct. Balto. Md. 21237</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star 8/6/91</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lucy C. Estep</i>				22. NAME AND ADDRESS OF FACILITY <b>Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>INFECTIVE ENDOCARDITIS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>CHRONIC INTRAVENOUS DRUG ABUSE</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>INSPECTION</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle, Jr.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>07 25 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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REG. NO.

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

at 11:00

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The last of the death certificate to be retained by the hospital or attending physician. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21868					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <b>HAZEL ROSELLA GREEN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 03 91</b>				3. TIME OF DEATH M <b>02:40am</b>					
4. SOCIAL SECURITY NUMBER <b>232-10-5182</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>71</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS <b>0 0</b>		IF UNDER 24 HRS. HOURS MIN. <b>0 0</b>		7. DATE OF BIRTH (Month, Day, Year) <b>June 22, 1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Keyser, W.Va.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SACRED HEART HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>CUMBERLAND, MD.</b>				9c. COUNTY OF DEATH <b>ALLEGANY</b>					
RESIDENCE OF DECEDENT													
10a. STATE <b>W.Va.</b>		10b. COUNTY <b>Mineral</b>		10c. CITY, TOWN OR LOCATION <b>Keyser</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER <b>Rt. 1 Limestone Road</b>				10f. ZIP CODE <b>26726</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— if yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>8</b> Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Ellison Courtney</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Rosella Kuykendall</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Marsha R. Combs</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>112 "A" Street Keyser, W.Va. 26726</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Potomac Memorial Gardens 8/06/91</b>		DATE <b>8/06/91</b>		20c. LOCATION — City or Town, State <b>Keyser, W.Va.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Brain L. Smith</i>				22. NAME AND ADDRESS OF FACILITY <b>85 S. Main Street Rotruck Funeral Home Keyser, W.Va. 26726</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ c. _____ d. _____ <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. _____ c. _____ d. _____										Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard G. Schmitt M.D.</i>				29c. LICENSE NUMBER <b>026333</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type/Print) <i>Richard G. Schmitt M.D. 900 Seton Dr. Cumberland Md 21502</i>													
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

From 1st to 10th  
The first 10 days of the month

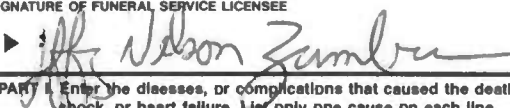


1st/2nd 3rd/4th 5th/6th 7th/8th 9th/10th  
The first 10 days of the month

**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

91 21869

1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALLEN WINFIELD GARBER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1210</b> M	
4. SOCIAL SECURITY NUMBER <b>219-16-1461</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-22-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>HARBOR HOSPITAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>ANNE ARUNDEL</b>		10c. CITY, TOWN OR LOCATION <b>GLEN BURNIE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>161 MARGATE DR.</b>				10f. ZIP CODE <b>21060</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7</b> College (1-4 or 5+) <b>NONE</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ROUTE SALESMAN</b>		16b. KIND OF BUSINESS/INDUSTRY <b>KOONTZ CREAMERY</b>	
17. FATHER'S NAME (First, Middle, Last) <b>IRA GARBER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PEARL BURRIER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>HILDA M. GARBER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>SAME AS ITEM 10 E</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GLEN HAVEN MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>GLEN BURNIE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME</b> <b>1 SECOND AVE. S.W. GLEN BURNIE, MD 21061</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Severely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Severe COPD</b> DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):  DUE TO (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER 		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>T. Allison, EMERGENCY MEDICINE PHYSICIAN HHC Emergency Dept Balt Md.</b>							
31. DATE FILED (Month, Day, Year) <b>8/10 AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be secured within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached and filed with the burial-transit permit.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21870	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Paul Henry Hoblitz				2. DATE OF DEATH MONTH DAY YEAR Aug. 10, 1991		3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER 214-18-2409		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) 70 YRS.		7. DATE OF BIRTH (Month, Day, Year) Aug. 2, 1921		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) Francis Scott Key Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Essex		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER 4 Terrace Road				10f. ZIP CODE 21221		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 8th		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) City School		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Joseph Hoblitz				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sofie Imhoff					
19a. INFORMANT'S NAME (Type/Print) Levora Hoblitz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4 Terrace Road Baltimore Md. 21221					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Gardens of Faith 8/12/91		DATE 8/12/91		20c. LOCATION — City or Town, State Rossville Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Connelly Funeral Home				22. NAME AND ADDRESS OF FACILITY ConnellyFuneralHome300MAceAve.21221					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Acute Myocardial Infarction DUE TO (OR AS A CONSEQUENCE OF): ASCVD Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { Diabetes mellitus DUE TO (OR AS A CONSEQUENCE OF): PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hypertension Old C.V.A.								Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER A. [Signature]				29c. LICENSE NUMBER D17728		29d. DATE SIGNED (Month, Day, Year) 8-11-91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) BA YIN OUNG, M.D., 8022 BELAIR ROAD. 21236									
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE [Signature]					

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA M. HOFFMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>4:35 P.M.</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-2737</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>67</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 17 1923</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>GREATER BALTIMORE MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON, MD.</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Sparks</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>15801 Buffalo Run Road</b>				10f. ZIP CODE <b>21152</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaker</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Charles Joseph Fischer</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Catherine Heibler</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Ann Ensor</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>15801 Buffalo Run Road, Sparks, Md. 21152</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Most Holy Redeemer Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Bryan W. Clary</b>				22. NAME AND ADDRESS OF FACILITY <b>Lemmon-Mitchell-Wiedefeld Timonium, Md. 21093</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>ASCVD</b> <b>Due to (or as a consequence of):</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>Diabetes Mellitus</b> <b>Due to (or as a consequence of):</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Charles F. O'Donnell</b>				29c. LICENSE NUMBER <b>D-09383</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Charles F. O'Donnell (MD) - 2304 Wonderview Rd Timonium Md 21093</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jane Davidson-Pendall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the Bureau of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>HAROLD F. HANLEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 7, 1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>220-05-4179</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 25, 1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>Glen Burnie</b>			
10. COUNTY OF DEATH <b>Anne Arundel</b>				11. FACILITY NAME (If not institution, give street and number) <b>North Arundel General Hospital</b>			
12. RESIDENCE OF DECEDENT				13. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
14. STATE <b>Maryland</b>		15. COUNTY <b>Anne Arundel</b>		16. CITY, TOWN OR LOCATION <b>Hanover</b>		17. ZIP CODE <b>21076</b>	
18. CITIZEN OF WHAT COUNTRY? <b>United States</b>				19. STREET AND NUMBER <b>7102 Ohio Avenue</b>			
20. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		21. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		22. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		23. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
24. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b> College (1-4 or 5+) <b>--</b>		25. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Painter</b>		26. KIND OF BUSINESS/INDUSTRY <b>Decorating</b>			
27. FATHER'S NAME (First, Middle, Last) <b>James William Hanley</b>				28. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian Booth</b>			
29. INFORMANT'S NAME (Type/Print) <b>Mrs. Diane L. Zaworski</b>				30. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>204 Newport Drive Severna Park, MD. 21146</b>			
31. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		32. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Maryland Veterans Cem 8/12/91 Crownsville, MD.</b>		33. DATE <b>8/12/91</b>		34. LOCATION — City or Town, State	
35. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Valerie S. Polynick</i>				36. NAME AND ADDRESS OF FACILITY <b>Mc Cully Funeral Home of Pasadena 3204 Mountain Rd. Pasadena, MD. 21122</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Serious Disorder</b> Due to (or as a consequence of): a. b. c. d. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { a. b. c. d. 							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William P. Jones, MD</i> Deputy				29c. LICENSE NUMBER <b>D 06054</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William P. Jones, MD PO Box 99 20711</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

2-10-55

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21873			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>Mary L Hodges</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5 22 P</b>			
4. SOCIAL SECURITY NUMBER <b>214 26 5585</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/25/19</b>		8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Bon Secour Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>915 McKean Avenue</b>				10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S. OF A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>N/A</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PRESSER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>SHIRT MFG. COMPANY</b>			
17. FATHER'S NAME (First, Middle, Last) <b>ALEX ROBINSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH ROBINSON</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MRS. CHARLOTTE PALMER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3105 THORNFIELD ROAD BALTIMORE, MARYLAND 21207</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEMORIAL PARK 8/13/91</b>				20c. LOCATION — City or Town, State <b>BALTIMORE, MD. BALTO. CO.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lewis T. Gwynn</b>				22. NAME AND ADDRESS OF FACILITY <b>LEWIS T. GWYNN FUNERAL HOME 21215-6393 4517 PARK HEIGHTS AVE. BALTIMORE, MARYLAND</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Carcinoma</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>carcinoma of stomach</b> c. d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic anemia</b> <b>seizure disorder</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> A <input type="checkbox"/> P <input type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Baskaran</b>				29c. LICENSE NUMBER <b>D21649</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-10-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SAM BASKARAN BASKARAN 3455 Wickens Ave Baltimore MD 21229</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>							

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Ellen M. Hobbs</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08-09-1991</b>		3. TIME OF DEATH <b>8:30 A. M.</b>	
4. SOCIAL SECURITY NUMBER <b>217-76-1706</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-22-1912</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>4433 Raspe Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4433 Raspe Avenue</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>History Clerk</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Hopkins Hospital</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Daniel P. Corey</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mabel Davis</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Marjorie R. Hoffmaster</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4433 Raspe Avenue, Baltimore, Maryland 21206</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glen Haven</b>		DATE <b>8/12</b>		20c. LOCATION — City or Town, State <b>Glen Burnie Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Kathleen M. Murphy</i>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ACZMimer's</b> Approximate Interval Between Onset and Death <b>1 yr.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dr. George Lowe</i> 29c. LICENSE NUMBER <b>D20673</b> 29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. George Lowe, 5810 Belair Road, Baltimore, Maryland 21206</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Lidia Davidson-Randell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Lillie F. JONES</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:20 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-10-3855</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>93</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-25-1897</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>DEATON Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>704 E. CHASE STREET</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>DOMESTIC</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN HILL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MATTIE TURNER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MOLLIE WALKER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>656 CHARRAWAY RD/BALTIMORE, MD 21229</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>PARKWOOD CEMETERY</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Calvin L. Williams</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Vascular disease, CVA seizure disorder</b>						Approximate Interval Between Onset and Death <b>Acute</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Arthur J. M.D.</b>				29c. LICENSE NUMBER <b>D14622</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/8/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>H.C. Mincee, 6115 Chase St, Balto Md 21230</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rodriguez</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial/transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JACKSON, Doris</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:50 A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-22-7995</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>62</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>6/13/29</b>		8. BIRTHPLACE (State or Foreign Country) <b>Md.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>719 E. 21st Street</b>				10f. ZIP CODE <b>21218</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Afr. American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Robert Brooks</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Amelia Brooks</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Riley Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>719 E. 21st Street Baltimore, Md. 21218</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest</b>		20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leola A. Estep</i>		22. NAME AND ADDRESS OF FACILITY <b>Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. 21217</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>MULTIPLE-Organ Failure</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <b>minutes</b> <b>days</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Heidi Frankel</i> <b>Housestaff Surgeon</b>					
29c. LICENSE NUMBER <b>D39953</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-10-91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Heidi Frankel Sinai Hospital Baltimore, MD</b>							
31. DATE FILED (Month, Day, Year) <b>8-10-91 AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>Jana Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.


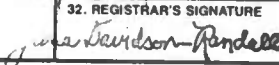
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MOSES JONES III</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>212-33-6338</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <b>4</b>		7. DATE OF BIRTH (Month, Day, Year) <b>4/11/1991</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>FRANCIS S. KEY MEDICAL CENTER</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		8c. COUNTY OF DEATH -----	
9a. RESIDENCE OF DECEDENT 10a. STATE <b>Maryland</b>				10b. COUNTY -----		10c. CITY, TOWN OR LOCATION <b>Balto. City, Md.</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3226 Noble St.</b>		10f. ZIP CODE <b>21224</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>None</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>None</b>		16b. KIND OF BUSINESS/INDUSTRY -----	
17. FATHER'S NAME (First, Middle, Last) <b>Moses Jones, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kendra Jamerson</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mr. Henneth Jamerson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1521 E. Clement St. Balto. Md. 21230</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 8/14</b>		20c. LOCATION — City or Town, State <b>Md. Catonsville, Balto. Co.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Balto. Md. 21230 McCully Funeral Home, 130 E. Fort Ave.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CONGENITAL HEART DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <b>1</b> <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 29) (Type, Print) <b>MARIO F. GOLIE, JR., MD</b>				111 PENN STREET, BALTIMORE, MARYLAND 21201			
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR					REG. NO. 91 21878					
1. DECEDENT'S NAME (First, Middle, Last) <b>MABEL JONES</b>					2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>09:30 AM</b>			
4. SOCIAL SECURITY NUMBER <b>172.34.3954</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>86</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-29-1904</b>		8. BIRTHPLACE (State or Foreign Country) <b>Pennsylvania</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>					9b. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>			9c. COUNTY OF DEATH <b>A.A. COUNTY</b>		
RESIDENCE OF DECEDENT										
10a. STATE <b>Pennsylvania</b>		10b. COUNTY <b>Luzerne</b>		10c. CITY, TOWN OR LOCATION <b>Kingston</b>			10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>125 S. Maple Ave.</b>				10f. ZIP CODE <b>18704</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Years</b> College (1-4 or 5+) <b>NONE</b>			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Clerk</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Retail Store</b>				
17. FATHER'S NAME (First, Middle, Last) <b>David Johns</b>					18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margretta (Unknown)</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Carol Young</b>					19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>852 Riverside Drive, Pasadena, Maryland 21122</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)			20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fern Knoll Burial Park</b>			20c. LOCATION — City or Town, State <b>Dallas, Pennsylvania</b>		20d. DATE		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>R. George Hopkins</i>					22. NAME AND ADDRESS OF FACILITY <b>SINGLETON FUNERAL HOME</b> <b>1 Second Ave. S.W. Glen Burnie, Md. 21061</b>					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Heart failure</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerosis</b> <b>Myocardial infarction</b>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Arterial Renal failure</b>										
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide			26a. DATE OF INJURY (Month, Day, Year)		26b. TIME OF INJURY M		26c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>J.M. Ramirez</i>					29c. LICENSE NUMBER <b>D36256</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) <b>JORGE M. RAMIREZ, M.D. 7845 OAKWOOD ROAD, #205/GLEN BURNIE, MARYLAND 21061</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>			32. REGISTRAR'S SIGNATURE <i>John Davidson</i>							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Lawrence Jesse Lawrence KIDD KIDD</i>		2. DATE OF DEATH MONTH <i>8</i> DAY <i>6</i> YEAR <i>91</i>		3. TIME OF DEATH <i>6:00 P.M.</i>	
4. SOCIAL SECURITY NUMBER <i>215-05-0547</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>86</i> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <i>1/1/1905</i>		8. BIRTHPLACE (State or Foreign Country) <i>Virginia</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Joseph Richey House</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH <i>N/A</i>	
10a. STATE <i>Maryland</i>		10b. COUNTY <i>Anne Arundel</i>		10c. CITY, TOWN OR LOCATION <i>Glen Burnie</i>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <i>6 Belvedere Avenue</i>		10f. ZIP CODE <i>21061</i>	
10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12th</i> College (1-4 or 5+) <i>5</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Maintenance Engineer</i>		16b. KIND OF BUSINESS/INDUSTRY <i>Chesapeake</i>	
17. FATHER'S NAME (First, Middle, Last) <i>Oscar Kibble Kidd</i>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Estella Johnson Kidd</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Mrs. Ida Mae Kidd</i>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>6 Belvedere Avenue, Glen Burnie, Maryland 21061</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Glen Haven Memorial Park 8/9/91 Glen Burnie, Maryland</i>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> Kevin E. Ecker		22. NAME AND ADDRESS OF FACILITY <i>McCully Funeral Home of Brooklyn 237 E. Patapsco Ave., Balto., Md. 21225</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Acquired Immune Deficiency Ds.</i> <i>Carcinoma of Bladder</i>		Approximate Interval Between Onset and Death <i>7yrs.</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <i>Hospice</i>			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Robert C. Irwin MD</i>		29c. LICENSE NUMBER <i>D08900</i>	
29d. DATE SIGNED (Month, Day, Year) <i>8-6-91</i>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Robert C. Irwin MD 828 N. Eutaw St. Balto Md 21201</i>			
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>DOBA L. KNIGHT</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:10 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-22-4083</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2/19/19</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Sinai Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10a. STATE <b>MD.</b>		10b. COUNTY		10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
10e. STREET AND NUMBER <b>2708 Uhler Avenue</b>		10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>Simon Bozo</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Penny Langley</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bernadette Thomas</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2709 Uhler Ave. Balto., MD. 21215</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Woodlawn Cem. 8-16-91</b>		20c. LOCATION — City or Town, State <b>Woodlawn, MD.</b>		22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Doretha Hector #281</b>		22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>HEART FAILURE</b> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>ISCHEMIC HEART DISEASE</b>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, term, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>HOUSESTAFF</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>EUGENE GO SINAI HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Lelia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ANOTHER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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State of Texas

County of ...

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAMES T KINARD</b>				2. DATE OF DEATH MONTH <b>08</b> - DAY <b>11</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>2:40 A M</b>	
4. SOCIAL SECURITY NUMBER <b>120 26 0846</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>56</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/17/35</b>	
8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Harbor Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>		10b. COUNTY <b>Anne Arundel</b>		10c. CITY, TOWN OR LOCATION <b>Glenburnie</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>6378 C Centenial Ct.</b>				10f. ZIP CODE <b>21061</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1952--1974</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Manager</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Food</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Kinard</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Mark Edmondson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7787 Cox Point Ct. Balto., Md. 21226</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Lakeview</b>		20c. LOCATION — City or Town, State <b>Carrol Co.,</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vaughn C. Green</b>		22. NAME AND ADDRESS OF FACILITY <b>James Morton FH 1709 Laurence</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MALIGNANT BRADY ARYTHMIAS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>SEVERE PERIPHERAL VASCULAR DISEASE</b> <b>HISTORY OF CVA, DVT,</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>SEVERE PERIPHERAL VASCULAR DISEASE</b> <b>HISTORY OF CVA, DVT,</b>							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28d. DESCRIBE HOW INJURY OCCURRED					
28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Anthee Nwandu M.D.</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HARBOR HOSPITAL CENTER, BALTIMORE MD</b>							
31. DATE FILED (Month, Day, Year) <b>8 AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Jeha Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL AND ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
 TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
 IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21882

1. DECEDENT'S NAME (First, Middle, Last) <b>Kim Sherwood Kendall</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>9:45 P M</b>	
4. SOCIAL SECURITY NUMBER <b>051 - 28 - 9777</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) <b>55</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Oct 14, 1935</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>7518 Browns Bridge Road</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Highland</b>		9c. COUNTY OF DEATH <b>Howard</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Highland</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>7518 Browns Bridge Road</b>			
10f. ZIP CODE <b>20777</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Korea</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>4 Years</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Administrator</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Department of Defense</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George E. Kendall</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Kaythryn Souder</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gregory D. Kendall</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1000 Wren Avenue, Miami Springs, Florida 33166</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc.</b>		DATE <b>8/12</b>		20c. LOCATION — City or Town, State <b>Catonsville, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Donaldson Funeral Home, P.A. 313 Talbott Ave. Laurel, Maryland 20707</b>			
23. PART I. Enter the disease(s) or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Respiratory Failure</b> SEQUENTIALLY LIST CONDITIONS, IF ANY, LEADING TO IMMEDIATE CAUSE. ENTER UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>Metastatic Squamous Cell Lung Cancer</b> PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify) 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined 28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE NOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 29b. SIGNATURE AND TITLE OF CERTIFIER 29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Thomas A. Belknap 7525 Greenway Center Dr. Greenbelt, MD 20770</b> 31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b> 32. REGISTRAR'S SIGNATURE 							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FLOZENA KENNEDY</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-16-16</b>	
8. BIRTHPLACE (State or Foreign Country) <b>SC</b>		9a. FACILITY NAME (If not institution, give street and number) <b>1835 W. Fayette St</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1835 W. Fayette St</b>		10f. ZIP CODE <b>21223</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or S+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)			
19a. INFORMANT'S NAME (Type/Print) <b>Joseph S. Kennedy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1835 W. Fayette St., Baltimore, MD. 21223</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Va Cem</b>		20c. LOCATION — City or Town, State <b>8-14 Owings Mills, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charlene D. Brown</i>				22. NAME AND ADDRESS OF FACILITY <b>Joseph H. Brown Jr. F.H. P.A. 1913 W. Baltimore St. Balto., MD. 21223</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CARDIOPULMONARY ARREST</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>b. METASTATIC ENDOMETRIAL CANCER</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Nancy M. Hammond MD</i> CHIEF RESIDENT				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>NANCY M. HAMMOND MD UNIVERSITY OF MARYLAND MEDICAL CENTER DEPT OB-GYN 22 S. GREENE ST BALTIMORE MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Andrew Ponder</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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2000-05-12

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>THELMA LAWSON</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:35 P M</b>	
4. SOCIAL SECURITY NUMBER <b>216-32-1112</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Feb 20 1918</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5120 Queensbury Avenue</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th Grade</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Domestic</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Joseph Henderson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Elenora Burton</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Rosa Lee Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5120 Queensbury Ave. Baltimore, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Memorial Park 8/14 Baltimore Co., MD</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Vernon R. Bailey</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CANCER OF THE LUNG</b> <b>ARTERIAL HYPERTENSION</b>							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/09/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT, MD, DCME 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit certificate. 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>ALFRED M. LITZ SR.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>23:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>215-03-9985</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH Month, Day, Year <b>Mar. 4, 1916</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>UNION MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4208 Willshire Avenue</b>	
10f. ZIP CODE <b>21206</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>Army WW II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6</b> College (1-4 or 5+) <b>College</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Steel Worker</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Beth. Steel Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George M. Litz</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Edith E. Bruff</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Jeanette Litz</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4208 Willshire Avenue Baltimore, Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Veterans 8/16/91</b>			
20c. LOCATION — City or Town, State <b>Owings Mills, Md.</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Milton J. Knight Jr.</b>			
22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Maryland Leonard J. Ruck, Inc. 5305 Harford Rd 21214</b>				23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>SEVERE METABOLIC ACIDOSIS</b> DUE TO (OR AS A CONSEQUENCE OF):  b. <b>SEPTIC SHOCK</b> DUE TO (OR AS A CONSEQUENCE OF):  c. <b>PERFORATED DIVERTICULITIS OF SIGMOID COLON</b> DUE TO (OR AS A CONSEQUENCE OF):  d.  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>PANCYTOPENIA WITH AGRANULOCYTOSIS</b>				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carlos M. Orbegoso M.D.</b>			
29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <b>8-12-91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>CARLOS M. ORBEGOSO M.D. UNION MEMORIAL HOSPITAL</b>				31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Albert L. Lowenstein</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8-10-1991</b>		3. TIME OF DEATH M <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>217-14-6230</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-15-1921</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Med. Cnt.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>-----</b>				RESIDENCE OF DECEDENT			
10a. STATE <b>Md/</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>5208 McFaul Rd. East</b>				10f. ZIP CODE <b>21206</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Machinist</b>		16b. KIND OF BUSINESS/INDUSTRY <b>B.G.&amp;E.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert L. Lowenstein, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Mildred A. Lowenstein</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5208 McFaul Rd. East Balto., Md. 21206</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cem.</b>		DATE <b>Balto., Md.</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 		22. NAME AND ADDRESS OF FACILITY <b>Hartley Miller Funeral Home 7527 Harford Rd. Balto. Md. 21234</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Severely A.S.H.D. → <b>Severe A.S.H.D.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHF</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death <b>Sudden</b> <b>Found in back of room</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>DO 2022</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-12-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LEOPOLDO GROSS M.D. 405 Stemmers Run Rd 21221</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE 					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE REGISTRAR OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate must be completed and signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, and item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21887			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Betty Moore				8 8 91				0116 A M			
4. SOCIAL SECURITY NUMBER		6. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
218366537		1 <input type="checkbox"/> M <input checked="" type="checkbox"/> F		51 YRS.		1-21-40		Maryland			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
St. Agnes Hospital 900 S. Cator				Baltimore, Md.							
RESIDENCE OF DECEDENT											
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?					
Maryland		Anne Arundel		Severn		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
7907 Pavilion Dr.				21114				U. S. A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR DR DATES		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO Specify:		Specify:		Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5 +)				Beautician/Counselor				D.C. Children Center			
High School											
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
Jean Constance Hall				Bertha Marie Coleman							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
Sharon Moore				7907 Pavillion Drive Severn, Maryland							
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State					
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		1st Baptist Church Cem		8/12		Guildford, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
Herbert E. Miller				Nutter Funeral Homes, 2501 Gwynns Falls Parkway Baltimore, Maryland 21216							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. presumed cardiac disease											
b. diabetes mellitus and renal failure											
c. renal failure											
d. renal failure											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.											
24a. WAS AN AUTOPSY PERFORMED?								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED			
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined						1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)				29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER			
1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				James J. Carey				D 3333			
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)			
James J. Carey				D 3333				8 Aug 91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)				31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE			
JAMES J. CAREY, M.D. 716 MAIDEN CHOICE LA-21228				8/8/91				John Davidson-Randall			

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IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21888									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES MORAN</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>				3. TIME OF DEATH <b>6:40 P M</b>									
4. SOCIAL SECURITY NUMBER <b>216-44-1681</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		IF UNDER 1 YEAR MONTHS <b>1</b> DAYS <b>11</b>		IF UNDER 24 HRS. HOURS <b>11</b> MIN. <b>40</b>		7. DATE OF BIRTH (Month, Day, Year) <b>March 29, 1908</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>St. Agnes Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH <b>Baltimore</b>									
RESIDENCE OF DECEDENT																	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <b>5919 The Alameda</b>				10f. ZIP CODE <b>21239</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>9</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Baltimore City Police</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Public Safety</b>									
17. FATHER'S NAME (First, Middle, Last) <b>Edward Moran</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian M. Simpson</b>													
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Janice M. Nizer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5919 The Alameda Baltimore, Maryland 21239</b>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Dulaney Valley Cemetery</b>		DATE <b>8/16/91</b>		20c. LOCATION — City or Town, State <b>Baltimore Maryland</b>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Ruck</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>													
23. PART I. Enter the disease or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Untractable Pulmonary Edema</b> DUE TO (OR AS A CONSEQUENCE OF): <b>CHF</b> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): <b>Multi-infarct dementia</b>												Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Multi-infarct dementia</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
28e. PLACE OF INJURY — A1 home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mupombo KAN KONGE</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>Aug 11, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ST. AGNES HOSPITAL</b>																	
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>													

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CAROLYN MAYS</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 07 1991</b>		3. TIME OF DEATH <b>12:02 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>219-40-2898</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/31/1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2115 W. FAYETTE STREET</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE MAYS</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARGIE HARRIS MAYS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GEORGE MAYS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2115 W. FAYETTE STREET, BALTIMORE, MARYLAND 21223</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>METRO CREMATORY</b>		DATE <b>8/8/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>ESTEP BROTHERS FUNERAL HOME, P.A. 1300 EUTAW PLACE, BALTIMORE, MD. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>HYPOTENSION</b> DUE TO (OR AS A CONSEQUENCE OF):				Approximate Interval Between Onset and Death <b>4 hrs</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST		b. <b>SEIZURE</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>72 hrs</b>	
		c. <b>Obstructive Pulmonary Disease</b> DUE TO (OR AS A CONSEQUENCE OF):				<b>2 years</b>	
		d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		24e. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>William H. Goodman MD</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William H Goodman 600 N Wolfe St Balt MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The funeral director shall file the death certificate with the State Department of Health and Mental Hygiene within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, or item 23 is marked, the medical examiner must be notified at once.

12:58

2:14

1. 10/10/10 10:10  
2. 10/10/10 10:10  
3. 10/10/10 10:10



91 21890

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY R. MYERS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <b>220-22-4599</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Aug. 13, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>Eastpoint Nursing Home</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Eastpoint</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Rosedale</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>8064 Roslyn Ave.</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>Davison Transfer</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Atkinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Carrie Jones</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Annabell Phillip</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1322PineGroveAve. Baltimore Md. 21237</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Connelly Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY <b>Connelly FuneralHome300MAceAve. 21221</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardio-Respiratory failure</b>							
a. DUE TO (OR AS A CONSEQUENCE OF): <b>ASCVD</b>							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Old CVA to left hemiparesis - Parkinson's disease</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>B. Matos M.D. - Att. Physician</i>				29c. LICENSE NUMBER <b>D-14618</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BIENVENIDO R. MATOS, M.D. 21 CRANBROOK RD - COLKEYSVILLE, MD 21036</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Jolia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

08015 18

ITEM:19b per FH  
G-678 8/15/91 cm

91 21891

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Walter E MITZEL</b>				2. DATE OF DEATH MONTH <b>AUGUST</b> DAY <b>10</b> , YEAR <b>1991</b>		3. TIME OF DEATH <b>12:05 A</b>	
4. SOCIAL SECURITY NUMBER <b>215-09-4044</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>73</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4-1-1918</b>	
8. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD.</b>				10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>1102 Middleway Road</b>			
10f. ZIP CODE <b>21220</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) <b>6th Grade</b>		16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Plumber</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self Employed</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Albert E. Mitzel</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Kathene</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Roberta M. Mitzel</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1102 Middleway Road Baltimore, Md. - 21202 21220</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Park 8-14-91 Balto. Md.</b>		20c. LOCATION — City or Town, State			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Barbara M. Murphy</b>				22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. Baltimore, Md. - 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Immediate Cause (Final disease or condition resulting in death) →</b> <b>Constitutional heart failure</b> <b>ASCVD</b> <b>years</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>Cirrhosis of liver</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>R. Matos, M.D. - Cert. Physician</b>				29c. LICENSE NUMBER <b>D14618</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>BIENVENIDO R. MATOS, M.D. - 21 Cranbrook Rd. Cat Key, Md. 21036</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>					

10015 12

ITEM:4 per FH  
G-678 8/16/91 cm

91 21892

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARLENE A. NICHOLS				2. DATE OF DEATH MONTH DAY YEAR August 12, 1991		3. TIME OF DEATH 5:35 A M							
4. SOCIAL SECURITY NUMBER 217-30-3984		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 56 YRS.		7. DATE OF BIRTH (Month, Day, Year) NOV. 14, 1934		8. BIRTHPLACE (State or Foreign Country) MARYLAND					
9a. FACILITY NAME (If not institution, give street and number) FRANKLIN SQUARE HOSPITAL				9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH Baltimore					
10a. STATE MARYLAND		10b. COUNTY BALTIMORE		10c. CITY, TOWN OR LOCATION PERRY HALL				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
10e. STREET AND NUMBER 9802 GUNFORGE ROAD				10f. ZIP CODE 21128		10g. CITIZEN OF WHAT COUNTRY? U. S. A.							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER		16b. KIND OF BUSINESS/INDUSTRY OWN HOME									
17. FATHER'S NAME (First, Middle, Last) FERDINAND SINCLAIR				18. MOTHER'S NAME (First, Middle, Maiden Surname) FLORENCE KELLY									
19a. INFORMANT'S NAME (Type/Print) HOWARD NICHOLS III (SON)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 9802 GUNFORGE ROAD, PERRY HALL, MD. 21128									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) PARKWOOD CEMETERY		DATE		20c. LOCATION — City or Town, State BALTIMORE, MD.							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Charles H. Lynch</i>				22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 9705 BELAIR ROAD, BALTIMORE, MD. 21236									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Cardio - Pulmonary arrest</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Cerebral Edema</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Malignant Glioma</i> DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death <i>2 weeks</i> <i>7 months</i> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julian Davidson-Randall</i>		29c. LICENSE NUMBER D23607		29d. DATE SIGNED (Month, Day, Year) Aug 12, 1991							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)													
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE <i>Julian Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES LINDBERGH PETTY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 - 11 - 91</b>		3. TIME OF DEATH <b>6:38 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>238-38-3361</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-03-27</b>	
8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Harbor City Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Anne Arundel</b>	
10c. CITY, TOWN OR LOCATION <b>Severn</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>7992 Telegraph Road</b>	
10f. ZIP CODE <b>21144</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>World War II</b>				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>High School</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Truck Driver</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Bethlehem Steel Corp.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Guy Petty</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Sue Bright</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Gerogene C. Petty</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7992 Telegraph Road Severn, MD 21144</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Saints Rest Cemetery</b>		20c. LOCATION — City or Town, State <b>Harmons, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Herbert E. Nutter</b>				22. NAME AND ADDRESS OF FACILITY <b>Nutter Funeral Homes 2501 Gwynns Falls Parkway Baltimore, Maryland 21216</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MALIGNANT ARRHYTHMIAS</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>REFRACTORY CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CHRONIC RENAL FAILURE</b> <b>DIABETES MELLITUS</b> <b>HYPERTENSION</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Anthee Nwanda M.D.</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Anthee Nwanda HARBOR HOSPITAL CENTER, BALTIMORE, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Gina Davidson-Randell</b>			

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been filed with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

De: L



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21894

1. DECEDENT'S NAME (First, Middle, Last) <b>OBERLIN W PERRY Sr.</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>219-10-6240</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76 YRS.</b>	
7a. FACILITY NAME (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>		7b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		7c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>2122 NORTH FULTON AVENUE</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PASTOR EMERITUS</b>		16b. KIND OF BUSINESS/INDUSTRY <b>1ST BAPTIST CHURCH OF FAIRFIELD</b>		17. FATHER'S NAME (First, Middle, Last) <b>BOLSON PERRY</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>WATFORD</b>		19a. INFORMANT'S NAME (Type/Print) <b>CHANDLER RICKS PERRY</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2122 NORTH FULTON AVENUE, BALTO. MD. 21217</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>ARBUTUS CEMETERY</b>		20c. DATE <b>8-13-91</b>	
20d. LOCATION — City or Town, State <b>ARBUTUS, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charlene Burr</b>		22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTO. ST., BALTO. MD. P.O. BOX 4433, 21223</b>	
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CARCINOMA COLON</b> <b>Due to (or as a consequence of):</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> <b>b. Due to (or as a consequence of):</b> <b>c. Due to (or as a consequence of):</b> <b>d.</b>		Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Sher A Hashmi</b>		29c. LICENSE NUMBER <b>D24648</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8-7-1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SHER A HASHMI 2600 LIBERTY HEIGHTS Ave BALTIMORE</b>		31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>	
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Randy Paul</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>214-63-2615</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>35</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>8/12/55</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>(Home) 4011 Hilton Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md.</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4011 Hilton Road</b>		10f. ZIP CODE <b>21215</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Afr. American</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Willis Paul</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mattie Paul</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Hortense Paul</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4011 Hilton Road Balto. Md. 21215</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>6</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Western Star 8/15/91</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Cecil C. Estep</i>		22. NAME AND ADDRESS OF FACILITY <b>Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): <b>Immuno deficiency (CHIV)</b>  b. DUE TO (OR AS A CONSEQUENCE OF):  c. DUE TO (OR AS A CONSEQUENCE OF):  d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shay Physician</i>				29c. LICENSE NUMBER <b>D 20215</b>	
				29d. DATE SIGNED (Month, Day, Year) <b>8-9-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>K. NAIK, MD FOR DR. [Signature] 800 Braddock Ave, Baltimore MD 21217</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

IMPORTANT: If item 28 is completed, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the death certificate.  
IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <i>Margaret L. Palmer</i>								2. DATE OF DEATH MONTH <i>8</i> DAY <i>5</i> YEAR <i>91</i>				3. TIME OF DEATH <i>1052P</i>							
4. SOCIAL SECURITY NUMBER <i>216-28-5217</i>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>7-4-1930</i>		8. BIRTHPLACE (State or Foreign Country) <i>Maryland</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Liberty Med. Center</i>								9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore</i>				9c. COUNTY OF DEATH							
10a. STATE <i>MD.</i>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <i>4714 Wakefield Road Apt. 201</i>								10f. ZIP CODE <i>21216</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced				12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>							
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Disability</i>				16b. KIND OF BUSINESS/INDUSTRY <i>M.A.I.F.</i>											
17. FATHER'S NAME (First, Middle, Last) <i>Elijah Griffin</i>								18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Henrietta Allen</i>											
19a. INFORMANT'S NAME (Type/Print) <i>Charles Palmer</i>								19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>222A Chosin Circle Camp Pentlenton Calif 92054</i>											
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Allen Wash. Cem. 8-10-91</i>				20c. LOCATION — City or Town, State <i>Jessup, Maryland</i>											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Doretha Hector #281</i>				22. NAME AND ADDRESS OF FACILITY <i>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</i>															
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i> Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.												Approximate interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)															
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.																			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Er. Physician. Dr. 25228</i>												29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <i>8/5/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>A. AGRAWAL, Liberty Med Center</i>																			
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>								32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>											

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BOX 107

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8/20/91 rja

FOR  
1 - STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH91 21897  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) CARROLL W. ROYSTON				2. DATE OF DEATH MONTH DAY YEAR Aug. 10, 1991		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-07-8109		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 77 YRS.		7. DATE OF BIRTH (Month, Day, Year) Nov. 1, 1913	
9a. FACILITY NAME (If not institution, give street and number) 8204 White Manor Drive				9b. CITY, TOWN OR LOCATION OF DEATH Towson Lutherville		9c. COUNTY OF DEATH Baltimore	
10a. STATE Maryland				10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Towson Lutherville	
10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER 8204 White Manor Drive			
10f. ZIP CODE 21204 21093				10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES WW II		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Attorney		16b. KIND OF BUSINESS/INDUSTRY Law Firm			
17. FATHER'S NAME (First, Middle, Last) John Carroll Royston				18. MOTHER'S NAME (First, Middle, Maiden Surname) Wilhelmina Lohr			
19a. INFORMANT'S NAME (Type/Print) Mary C. Royston				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) Same as #10			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input checked="" type="checkbox"/> Other (Specify) Entombment		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Druid Ridge Cemetery 8/14/91		20c. LOCATION — City or Town, State Pikesville, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Ronald C. Schaper Jr.				22. NAME AND ADDRESS OF FACILITY Ruck Towson Funeral Home, Inc. 1050 York Rd., Towson, Md. 21204			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →							
a. <u>Uremia</u> DUE TO (OR AS A CONSEQUENCE OF):							
b. <u>ASCVD</u> DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Acute myocardial infarction</u>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER Dr. L. Myrton Gaines				29c. LICENSE NUMBER D03656		29d. DATE SIGNED (Month, Day, Year) August 12, 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. L. Myrton Gaines, 6565 N. Charles St., Towson, Md. 21204							
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE John Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



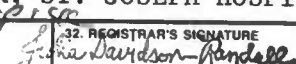
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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) VIRGINIA M. ROSS				2. DATE OF DEATH MONTH DAY YEAR AUG. 9, 1991		3. TIME OF DEATH 9:45 A M	
4. SOCIAL SECURITY NUMBER 214-22-6428		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 74 YRS.		7. DATE OF BIRTH (Month, Day, Year) MAY 4, 1917	
8. BIRTHPLACE (State or Foreign Country) W. VA.				9a. FACILITY NAME (If not institution, give street and number) 609 N. ROBINSON ST.		9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE	
9c. COUNTY OF DEATH -- --				10a. STATE MD.		10b. COUNTY -- --	
10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 609 N. ROBINSON STREET	
10f. ZIP CODE 21205				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: WHITE	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) NA College (1-4 or 5+) NA				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) BOTTLER		16b. KIND OF BUSINESS/INDUSTRY CALVERT DISTILLERY	
17. FATHER'S NAME (First, Middle, Last) RICHARD GIDLEY				18. MOTHER'S NAME (First, Middle, Maiden Surname) MAUDE KRAMMER			
19a. INFORMANT'S NAME (Type/Print) SARAH L. BURRISS (DGHTER)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 116 N. JANNEY STREET, BALTIMORE, MD. 21224			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WOODLAWN CEMETERY		20c. LOCATION — City or Town, State BALTIMORE, MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY SCHIMUNEK FUNERAL HOMES, INC. 3331 BREHMS LANE, BALTIMORE, MD. 21213			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic adenocarcinoma</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER D 14091		29d. DATE SIGNED (Month, Day, Year) 8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DR. ARTHUR SUPIK, ST. JOSEPH HOSPITAL 7620 YORK ROAD, BALTIMORE, MD.							
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KENNETH WILSON RICHARDSON</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 06 1991</b>		3. TIME OF DEATH <b>3:30 a m</b>					
4. SOCIAL SECURITY NUMBER <b>214-86-1014</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>25 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>12-27-65</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>2300 BLOCK SINCLAIR LANE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>			9c. COUNTY OF DEATH <b>BALTIMORE</b>				
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				
10e. STREET AND NUMBER <b>1613 East 25th Street</b>				10f. ZIP CODE <b>21213</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12) 12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>n/a</b>		16b. KIND OF BUSINESS/INDUSTRY <b>n/a</b>							
17. FATHER'S NAME (First, Middle, Last) <b>LEROY RICHARDSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>GLORIA LINDSAY</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Mrs. Gloria Richardson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4414 Franconia Drive Apt I Balto., md 21206</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>western star cemetery 8-10</b>		DATE <b>8-10</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Carlton C. Douglass</b>				22. NAME AND ADDRESS OF FACILITY <b>CARLTON C DOUGLASS FUNERAL SER 1701 McCulloh St 21217</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF BACK OF LEFT CHEST</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>08/06/1991</b>		28b. TIME OF INJURY <b>12:27am</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Mario F. Golle, Jr. MD</b>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/06/1991</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE, JR. MD 111 PENN STREET BALTIMORE, MARYLAND</b>								31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Jana Davidson-Randall</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4478-510

91 21900

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JAY JERLANDO ROY</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>03</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>11:58</b> p.m.	
4. SOCIAL SECURITY NUMBER <b>220-88-4029</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>22</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/24/69</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>Md.</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1612 N. Appleton St.</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Afr. American</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>William J. Roy Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dianna D. Roy</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dianna D. Roy</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1612 N. Appleton St. Balto. Md. 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Zion Baptist CH. Cem.</b>		20c. LOCATION — City or Town, State <b>Westmoreland, CO. MA.</b>		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Carl A. Estep</i>				22. NAME AND ADDRESS OF FACILITY <b>Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause of each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. GUNSHOT WOUNDS HEAD AND THIGHS</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>08/03/1991</b>		28b. TIME OF INJURY <b>11:15</b> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>ALLEY 1800 BLOCK BRUCE STREET</b>					
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>ALLEY, 1800 BLOCK BRUCE STREET BALTIMORE.</b>		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. MARYLAND <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/04/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD DCME 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jehane Dyllan Reuther</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08-09-91</b>		3. TIME OF DEATH <b>7:00p</b> M	
4. SOCIAL SECURITY NUMBER <b>413-72-3439</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>46</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-10-1944</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Tennessee</b>				9a. FACILITY NAME (If not institution, give street and number) <b>322 Tunbridge Road</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>	
9c. COUNTY OF DEATH <b>-----</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>-----</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>322 Tunbridge Road</b>	
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5+</b> College (1-4 or 5+) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Actress/Writer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Theater/Arts</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Louis P. Santi</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Opal E. Ellison</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Eric V. Reuther</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>322 Tunbridge Road, Balto., MD 21212</b>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematory, Inc. 8/12</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Hilary L. Stallings, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland 299 Frederick Rd, Balto., MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Metastatic Breast Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Peter Hinderberger, M.D.</b>				29c. LICENSE NUMBER <b>D3064P</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Peter Hinderberger, M.D., 4801 Yellowwood Avenue, Balto., MD 21209</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Peter Hinderberger</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be detached within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate is signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21902					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <i>Kamaroni, Mary</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>10</i> YEAR <i>91</i>				3. TIME OF DEATH <i>0445</i> <i>A</i> M					
4. SOCIAL SECURITY NUMBER <i>164 50 5637</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>89</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>June 21 1902</i>		8. BIRTHPLACE (State or Foreign Country) <i>Pennsylvania</i>					
9a. FACILITY NAME (If not institution, give street and number) <i>Shady Grove Adventest Hosp</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Rockville</i>				9c. COUNTY OF DEATH <i>Montgomery</i>					
10a. STATE <i>Md.</i>		10b. COUNTY <i>Montgomery</i>		10c. CITY, TOWN OR LOCATION <i>Rockville</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <i>299 Hurley Ave.</i>				10f. ZIP CODE <i>20850</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>White</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>8</i> College (1-4 or 5+) <i></i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Housewife</i>				16b. KIND OF BUSINESS/INDUSTRY <i>own home</i>					
17. FATHER'S NAME (First, Middle, Last) <i>Peter Kubis</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Julia Murczek</i>									
19a. INFORMANT'S NAME (Type/Print) <i>Cynthia C. Story</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8118 Woodloo Ct. Ellicott City, Md. 21043</i>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Charleroi Cemetery</i>				20c. LOCATION — City or Town, State <i>Charleroi, Pa.</i>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY <i>Ives-Pearson Funeral Homes Arlington, Va. 22201</i>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>CARDIO RESPIRATORY Arrest</i> Sequelae list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>Sepsis</i> <i>Asymptomatic</i> <i>Myocardial infarction</i>								Approximate Interval Between Onset and Death <i>Days</i>					
PART II. Other significant conditions contributing to death but not resulting in the underlying causes given in Part I. <i>Asymptomatic</i> <i>Myocardial infarction</i>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>Edward J. Devlin MD</i>		29c. LICENSE NUMBER <i>D33677</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/10/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Edward J Devlin MD 1994 Executive Park Lane Germantown MD</i>													
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>				<i>20874</i>					

Page 11

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				CERTIFICATE OF DEATH				REG. NO. 91-21903			
1. DECEDENT'S NAME (First, Middle, Last) EMIL P. ROB						2. DATE OF DEATH MONTH 8 DAY 10 YEAR 1991				3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER 215-32-3416			5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		8. AGE (In yrs. last birthday) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) 5-5-1906		8. BIRTHPLACE (State or Foreign Country) Maryland		
9a. FACILITY NAME (If not institution, give street and number) 16 Fox Hill Court						9b. CITY, TOWN OR LOCATION OF DEATH Perry Hall				9c. COUNTY OF DEATH Baltimore					
RESIDENCE OF DECEDENT															
10a. STATE Maryland		10b. COUNTY Baltimore		10c. CITY, TOWN OR LOCATION Perry Hall				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							
10e. STREET AND NUMBER 16 Fox Hill Court						10f. ZIP CODE 21128		10g. CITIZEN OF WHAT COUNTRY? USA							
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years College (1-4 or 5+) 4 years				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Garage/Service Station				16b. KIND OF BUSINESS/INDUSTRY Owner -Self-Employed							
17. FATHER'S NAME (First, Middle, Last) Frederick Rob						18. MOTHER'S NAME (First, Middle, Maiden Surname) Francis Runge									
19a. INFORMANT'S NAME (Type/Print) Blaine M. Franz				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 16 Fox Hill Court Perry Hall, Maryland 21128											
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 8 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Parkwood Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Lassahn Funeral Home				22. NAME AND ADDRESS OF FACILITY Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Coronary Artery disease Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. Hw CVA diabetes arthritis fracture										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DDA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 8 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Home				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER Richard Carey MD						29c. LICENSE NUMBER D31926		29d. DATE SIGNED (Month, Day, Year) 9/12/91							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Richard Carey 9105 Franklin Sq. Dr. Balto., Md. 21237 Suite 309 (682-8600)															
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Rendell											



**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE**  
**CERTIFICATE OF DEATH** REG. NO.

1. FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EDNA B. RITGERT</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>09</b> YEAR <b>91</b>		3. TIME OF DEATH <b>5:45 AM</b>	
4. SOCIAL SECURITY NUMBER <b>212 744 491</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>90</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>07/19/01</b>		8. BIRTHPLACE (State or Foreign Country) <b>Balto., Md.</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Good Samaritan Hospital</b>	
9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>N/A</b>		10a. STATE <b>Maryland</b>	
10b. COUNTY <b>N/A</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3211 Northway Drive</b>		10f. ZIP CODE <b>21234</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th Grade</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Home Maker</b>	
16b. KIND OF BUSINESS/INDUSTRY <b>Home</b>		17. FATHER'S NAME (First, Middle, Last) <b>John A. Banz</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Bocklage</b>	
19a. INFORMANT'S NAME (Type/Print) <b>Edna Kuhn</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3211 Northway Drive, Baltimore, Maryland 21234</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Sacred Heart of Jesus Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Kocher &amp; Murphy</b>	
22. NAME AND ADDRESS OF FACILITY <b>John C. Miller, Inc. 6415 Belair Road, Baltimore, Maryland 21206</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Respiratory failure.</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>Pneumonia.</b> <b>Bilateral pleural effusion</b>		Approximate Interval Between Onset and Death	
24. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>08/09/1991</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Champa Abeysinghe</b>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>08/09/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Good Samaritan Hospital Dr. Champa Abeysinghe, 5601 Loch Raven Boulevard, Baltimore, Maryland 21239</b>		31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Lisa Davidson-Rendell</b>	

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death. Page 4 should be filed within 72 hours after death, with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

**IMPORTANT:** If Item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

**TO BE COMPLETED BY FUNERAL DIRECTOR**

**TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION**

80278 10

91-4552-510

91 21905

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Donald S. Stewart</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 08 1991</b>		3. TIME OF DEATH <b>11:17 P M</b>	
4. SOCIAL SECURITY NUMBER <b>212-30-8699</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>59</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-25-31</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Cntr</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>				10b. COUNTY <b>Turners Station, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>109 CHESTNUT STREET</b>				10f. ZIP CODE <b>21222</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>10th</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY <b>BETHLEHEM STEEL/TANNING MILL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>EVERETTE STEWART</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY MITCHELL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>DONITA STEWART MEGGINSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>537 NEW PITTSBURG AVE./TURNERS STAT., MD 21222</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE CEMETERY</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Gladys Waver</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Inter Cerebral Hemorrhage</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <b>Inquiry</b>
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO							28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. DATE SIGNED (Month, Day, Year) <b>08 09 1991</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright</i>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright, MD DCME 111 Penn Street, Baltimore Maryland 21201</b>							32. REGISTRAR'S SIGNATURE <i>John Davidson</i>
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>							32. REGISTRAR'S SIGNATURE

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21906

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Martha Schultz</i>				2. DATE OF DEATH MOY DAY 8 13 91				3. TIME OF DEATH 3:15 P M					
4. SOCIAL SECURITY NUMBER 218-24-2106				5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 87 YRS.		7. DATE OF BIRTH (Month, Day, Year) 4-30-04		8. BIRTHPLACE (State or Foreign Country) MARYLAND			
9a. FACILITY NAME (If not institution, give street and number) MERCY HOSPITAL						9b. CITY, TOWN OR LOCATION OF DEATH BALTIMORE				9c. COUNTY OF DEATH			
10a. STATE MARYLAND				10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER GREENERY 1308 ELLWOOD AVENUE						10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: WHITE					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) VINCENT MODRAK						18. MOTHER'S NAME (First, Middle, Maiden Surname) KATHERINE MAKOWSKI							
19a. INFORMANT'S NAME (Type/Print) MRS. PATRICIA ROBEY						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 519 S. LUZERNE AVENUE BALTO. MD. 21224							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name If cemetery, specify cemetery or other place) HOLY ROSARY CEMETERY		DATE 8-16		20c. LOCATION — City or Town, State BALTO. CO. MD.					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Raymond L. Kaczorowski</i>						22. NAME AND ADDRESS OF FACILITY KACZOROWSKI FUNERAL HOME 2525 FLEET ST. BALTO. MD. 21224							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <i>Possible metastatic disease to liver</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Possible acute cholecystitis</i> DUE TO (OR AS A CONSEQUENCE OF): d.										Approximate Interval Between Onset and Death 10d unknown 10d			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Diabetes mellitus</i>										24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) N/A		28b. TIME OF INJURY N/A M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED N/A			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) N/A						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Michael J. Laub, M.D.</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/13/91					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Mercy Medical Center 301 St. Paul Place Balt MD</i>													
31. DATE FILED (Month, Day, Year) AUG 13 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>									

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death.

DATE DEPT. OF HEALTH AND MENTAL HYGIENE PRIOR TO BURIAL, CREMATION, OR REMOVAL.

IMPORTANT: If item 28 is completed, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21907

1. DECEDENT'S NAME (First, Middle, Last) <i>Enna Simms</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>8</i> YEAR <i>91</i>				3. TIME OF DEATH <i>1:19p</i> M	
4. SOCIAL SECURITY NUMBER <i>217-24-3573</i>		5. SEX <i>1</i> <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>6-30-03</i>		8. BIRTHPLACE (State or foreign Country) <i>Virginia</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>Bon Secours Hosp 2000 W Baltimore</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore, md</i>				9c. COUNTY OF DEATH	
10a. STATE <i>md</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore, md</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>520 Pymhurst St</i>				10f. ZIP CODE <i>21229</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>BLACK</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>?</i> College (1-4 or 5+) <i>?</i>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Domestic</i>				15b. KIND OF BUSINESS/INDUSTRY <i>md. National Bank</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Alexander Smith</i>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Jenny Johnson</i>					
19a. INFORMANT'S NAME (Type/Print) <i>John W. Simms Jr</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>8520 Greene Lane Baltimore MD 21207</i>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>St. Catharine Cem</i>		20c. LOCATION — City or Town, State <i>A.A. County MD</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Timothy Gordon</i>				22. NAME AND ADDRESS OF FACILITY <i>Locke Funeral Home 1304 N Central ave</i>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Septic Shock</i> DUE TO (OR AS A CONSEQUENCE OF): b. <i>Hyperosmolar coma</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Respiratory Failure</i> DUE TO (OR AS A CONSEQUENCE OF): d. Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Reg. Telum</i>				29c. LICENSE NUMBER <i>D18327</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/8/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Gebre-Mariam, Moses 4660 Wilkens Ave 21229</i>									
31. DATE FILED (Month, Day, Year) <i>AUG 13 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>					

1915 12

91 21908

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ADDIE SMITH</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>7</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>020 AM</b>	
4. SOCIAL SECURITY NUMBER <b>228-18-1366</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>77</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12/26/14</b>	
8. BIRTHPLACE (State or Foreign Country) <b>VIRGINIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>ST AGNES HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH				10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>708 REEDBIRD AVENUE APT #201</b>	
10f. ZIP CODE <b>21225</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RETIRED</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>CHARLES JOHNSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SADIE JOHNSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>CLAUDINE HALE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>708 REEDBIRD AVENUE BALTO. MD. 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Charles Brown</b>				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W. BALTO. ST. BALTO. MD., 21223 P.O. BOX 4433</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Severe Atherosclerotic disease</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <b>Severe Coronary Artery disease</b> <b>Long Hx, MI, diabetes mellitus</b>						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Phyllis M</b>				29c. LICENSE NUMBER <b>D31322</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/7/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>no maiden ch Lane Calounille by 2/22/91</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia K. Anderson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

00219 10

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ITEMS: 23, 27 per ME  
G-678 8/17/91 cm  
91-4585-003

91 21909

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Julia Kim Votolato				2. DATE OF DEATH MONTH 08 DAY 08 YEAR 1991		3. TIME OF DEATH 11:27 PM			
4. SOCIAL SECURITY NUMBER 214-62-2075		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 36 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09 17 1954		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) North Arundel Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Glen Burnie			9c. COUNTY OF DEATH Anne Arundel		
10a. STATE MD		10b. COUNTY ANNE ARUNDEL		10c. CITY, TOWN OR LOCATION SEVERN			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
10e. STREET AND NUMBER 7860 W.B. & A. Road				10f. ZIP CODE 21144		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: WHITE		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 1		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) HOMEMAKER			16b. KIND OF BUSINESS/INDUSTRY OWN HOME				
17. FATHER'S NAME (First, Middle, Last) JAMES H. BETTINGER				18. MOTHER'S NAME (First, Middle, Maiden Surname) DORIS C. HAMILTON					
19a. INFORMANT'S NAME (Type/Print) FRANK J. VOTOLATO				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS 10					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Meadowridge Memorial Park 8-12		20c. LOCATION — City or Town, State Elkridge, MD 21227					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE B. Henry Hopkins				22. NAME AND ADDRESS OF FACILITY SINGLETON FUNERAL HOME 1 SECOND AVE. S.W. GLEN BURNIE, MD 21061					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MYOCARDITIS DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER A. M. Dixon				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08 10 1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) A. M. Dixon 111 Penn Street, Baltimore Maryland 21201									
31. DATE FILED (Month, Day, Year) AUG 13 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Randall							

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

21 51003

*Handwritten signature or scribble*



1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21910

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MANCY C WHEELER</b>						2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 11, 1991</b>		3. TIME OF DEATH <b>11:00A</b> M	
4. SOCIAL SECURITY NUMBER <b>216-50-2869</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>44</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-31-47</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2401 CALLOW AVENUE</b>						10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>7TH</b> Elementary/Secondary (0-12) <b>College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>RICHARD SMITH</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALBERTA WHEELER</b>			
19a. INFORMANT'S NAME (Type/Print) <b>ALBERTA HORTON</b>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2401 CALLOW AVENUE/BALTIMORE, MD 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.) <b>KING MEMORIAL PARK CEM.</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Wane</b>						22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pulmonary Emboli</b>									<b>1 min</b>
Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST									
a. DUE TO (OR AS A CONSEQUENCE OF): <b>Myocardial Infarction</b>									<b>1 min</b>
b. DUE TO (OR AS A CONSEQUENCE OF): <b>DVT - Deep Venous Thrombosis</b>									<b>4/91</b>
c. DUE TO (OR AS A CONSEQUENCE OF): <b>Diabetes Mellitus</b>									<b>40 yrs</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Fungal Cholecystitis</b> <b>Cholecystectomy 8/9/91</b>									
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY —M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFY (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>(Mundy MD)</b>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>LINDA Mundy - Johns Hopkins Hospital - 600 W. Wolfe St - Balto. MD. 21205</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0060

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be retained by the funeral director.

IMPORTANT: Item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21911							
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH							
Lawrence Wright				MONTH 8 DAY 3 YEAR 91				7:11 P M							
4. SOCIAL SECURITY NUMBER		5. SEX		8. AGE (In yrs. last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.		7. DATE OF BIRTH		6. BIRTHPLACE (State or Foreign Country)			
216-01-2345		M 2 F		80 YRS.		MONTHS DAYS		HOURS MIN.		10/16/10		Md.			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH							
Mercy Hospital				Baltimore											
RESIDENCE OF DECEDENT															
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?							
Md.				Baltimore				1 YES 2 NO							
10a. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?							
4226 Parkton St.				21229				USA							
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.									
1 Never Married 2 Married		1 YES 2 NO		1 YES 2 NO		Specify:		Af. American							
3 Widowed 4 Divorced		IF YES, GIVE WAR OR DATES		Specify:											
15. DECEDENT'S EDUCATION				16a. DECEDENT'S USUAL OCCUPATION				16b. KIND OF BUSINESS/INDUSTRY							
(Specify only highest grade completed)				(Give kind of work done during most of working life. Do NOT use retired.)											
Elementary/Secondary (0-12) College (1-4 or 5+)				Retired				White Rose Paper CO.							
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)											
William Wright				Violet Levi											
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)											
Regina Wright				4226 Parkton St. Balto. Md. 21229											
20a. METHOD OF DISPOSITION				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)				20c. LOCATION — City or Town, State							
1 Burial 2 Cremation 3 Removal from State				Western Star				Catonsville, Md.							
4 Donation 5 Other (Specify)															
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY											
Paul A. Estep				Estep Brothers Funeral Home P.A. 1300 Eutaw Pl. Balto. Md. 21217											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.												Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Respiratory Arrest															
DUE TO (OR AS A CONSEQUENCE OF):															
b. Pneumonia															
DUE TO (OR AS A CONSEQUENCE OF):															
c. Chronic Lymphocytic Leukemia															
DUE TO (OR AS A CONSEQUENCE OF):															
d.															
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
												1 YES 2 NO		1 YES 2 NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?												26. PLACE OF DEATH (Check only one)			
1 YES 2 NO												HOSPITAL: 1 Inpatient 2 ER/Outpatient 3 DOA OTHER: 4 Nursing Home 5 Residence 6 Other (Specify)			
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED					
1 Natural 5 Pending Investigation				(Month, Day, Year)		M		1 YES 2 NO							
2 Accident															
3 Suicide															
4 Homicide															
8 Could not be determined															
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one)												29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.														8/3/91	
2 MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER															
John Adams M.D.															
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year)												32. REGISTRAR'S SIGNATURE			
AUG 13 1991												Julia Davidson-Rendell			



91 21912

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN WILCOXSON /John Moberly Wilcoxson</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>8:55 A M</b>	
4. SOCIAL SECURITY NUMBER <b>281-07-0875</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-09-1915</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Norwalk, Ohio</b>				9a. FACILITY NAME (If not institution, give street and number) <b>MARYLAND GENERAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>----</b>				10a. STATE <b>Maryland</b>			
10b. COUNTY <b>-----</b>				10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>301 McMechen</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th</b> College (1-4 or 5+) <b>3yrs</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Accountant</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Fred A. Wilcoxson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Effie M. Moberly</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Jean V. Wilcoxson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>301 McMechen Mem. Apt 1009 Balto., MD 21217</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Metro Crematroy, Inc. 8/12 Baltimore, MD</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Hilary L. Stallings, Jr.</b>				22. NAME AND ADDRESS OF FACILITY <b>Cremation Society of Maryland 299 Frederick Rd., Balto., MD 21228</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic small cell carcinoma of lung (extensively involving the liver)</b> DUE TO (OR AS A CONSEQUENCE OF): a. <b>Possible pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): b. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> d. <b>Coronary Artery Disease</b> DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <b>T. Kocsis, M.D.</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>August 10, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>T. Kocsis, M.D. c/o Maryland General Hospital</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91-21913

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First Middle, Last) <b>Mary White</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>				3. TIME OF DEATH <b>500 P M</b>			
4. SOCIAL SECURITY NUMBER <b>217-14-0120</b>				5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>68</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____	
9a. FACILITY NAME (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>			
10a. STATE <b>MD.</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>851 GEORGE STREET APT 7K</b>				10f. ZIP CODE <b>21201</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) _____ College (1-4 or 5+) _____				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>GEORGE W. BROWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>PEARL</b>							
19a. INFORMANT'S NAME (Type/Print) <b>LILLIAN BROWN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>851 GEORGE ST. BALTO. MD. 21201</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) _____				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>MT ZION</b>				DATE _____		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>JOSEPH H. BROWN JR. FUNERAL HOME, P.A. 1913 W BALTO ST, BALTO. MD. 21223, P.O. BOX 4433</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cancer of neck</b> DUE TO (OR AS A CONSEQUENCE OF): b. _____ DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____ _____											
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) _____							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>CKim Choong Kim, M.D.</b>				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Liberty Medical Center, Baltimore, MD</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 13 1991</b>				32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the physician has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 1215

1215



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21914					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <u>George H. Yaeger</u>				2. DATE OF DEATH MONTH <u>8</u> DAY <u>10</u> YEAR <u>71</u>				3. TIME OF DEATH <u>5 23 A M</u>					
4. SOCIAL SECURITY NUMBER <u>219-01-4355</u>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <u>70</u> YRS.		IF UNDER 1 YEAR MONTHS <u>0</u> DAYS <u>0</u>		IF UNDER 24 HRS. HOURS <u>0</u> MIN. <u>0</u>		7. DATE OF BIRTH (Month, Day, Year) <u>SEPT. 28, 1920</u>		8. BIRTHPLACE (State or Foreign Country) <u>MARYLAND</u>	
9a. FACILITY NAME (If not institution, give street and number) <u>HARBOR HOSPITAL</u>				9b. CITY, TOWN OR LOCATION OF DEATH <u>BALTIMORE</u>				9c. COUNTY OF DEATH <u>- - - -</u>					
RESIDENCE OF DECEDENT													
10a. STATE <u>MARYLAND</u>		10b. COUNTY <u>- - - -</u>		10c. CITY, TOWN OR LOCATION <u>BALTIMORE</u>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <u>3727 LYNDALE AVE.</u>				10f. ZIP CODE <u>21213</u>				10g. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES <u>WWII</u>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <u>WHITE</u>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <u>NA</u> College (1-4 or 5+) <u>NA</u>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <u>BOILER OPERATOR</u>				16b. KIND OF BUSINESS/INDUSTRY <u>B G &amp; E</u>							
17. FATHER'S NAME (First, Middle, Last) <u>ROBERT F. YAEGER</u>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <u>EDITH M. ARNOLD</u>									
19a. INFORMANT'S NAME (Type/Print) <u>MARY J. YAEGER (WIFE)</u>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <u>3727 LYNDALE AVE., BALTIMORE, MD. 21213</u>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <u>GARDENS OF FAITH CEMETERY</u>				20c. LOCATION — City or Town, State <u>BALTIMORE, MD.</u>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <u>[Signature]</u>				22. NAME AND ADDRESS OF FACILITY <u>SCHIMUNKER FUNERAL HOMES, INC.</u> <u>3331 BREHMS LANE, BALTIMORE, MD. 21213</u>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <u>Irreversible Heart Failure</u> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <u>Left lower lobe pneumonia</u> c. <u>Renal Failure</u> d. <u>Insulin dependent diabetes mellitus</u>										Approximate Interval Between Onset and Death <u>1 month</u> <u>1 month</u> <u>1 month</u> <u>Years</u>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide 3 <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <u>M</u>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.													
29b. SIGNATURE AND TITLE OF CERTIFIER <u>[Signature]</u>						29c. LICENSE NUMBER			29d. DATE SIGNED (Month, Day, Year) <u>8/10/91</u>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <u>Glenn Herman M.D. 3001 S. Hanover St Baltimore Md</u>													
31. DATE FILED (Month, Day, Year) <u>8/10/1991</u>				32. REGISTRAR'S SIGNATURE <u>Julia Davidson-Rendell</u>									

00218 17

91-4578-510

91 21915

FOR  
STATE  
REGISTRARItem: 23 part I, per MEO G-686 4/14/92 reb  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>DORA</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>09</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>4:19</b> P <sup>M</sup>	
4. SOCIAL SECURITY NUMBER <b>215-05-9748</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 14, 1895</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4106 FORDLEIGH RD.</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>					
17. FATHER'S NAME (First, Middle, Last) <b>NATHAN ALTSCHUL</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BETTY ROSENBERG</b>					
19a. INFORMANT'S NAME (Type/Print) <b>BENNETT ABELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3303 SMITH AVE. BALTIMORE, MD 21208</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BNAI ISRAEL</b>		DATE <b>8/11/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONGESTIVE HEART FAILURE due to</b> <b>dUE TO (OR AS A CONSEQUENCE OF):</b> <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> <b>and atrial fibrillation</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>d.</b>								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> XER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/10/1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLIE, JR., MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE PUBLIC: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>DOROTHY BOVA</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>09:11 AM</b>	
4. SOCIAL SECURITY NUMBER <b>219-12-9074</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-05-15</b>	
8. FACILITY NAME (If not institution, give street and number) <b>NORTH ARUNDEL HOSPITAL ASSOCIATION</b>				9. CITY, TOWN OR LOCATION OF DEATH <b>GLEN BURNIE</b>		10. COUNTY OF DEATH <b>A.A. COUNTY</b>	
11. STATE <b>MARYLAND</b>		12. COUNTY <b>ANNE ARUNDEL</b>		13. CITY, TOWN OR LOCATION <b>LINTHICUM</b>		14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
15. STREET AND NUMBER <b>515 DOGWOOD ROAD</b>				16. ZIP CODE <b>21090</b>		17. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
18. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		19. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR OATHS		20. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		21. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
22. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>H.S. grad</b> College (1-4 or 5+) <b>College</b>		23. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		24. KIND OF BUSINESS/INDUSTRY <b>-</b>			
25. FATHER'S NAME (First, Middle, Last) <b>WILLIAM VAN FOSSEN</b>				26. MOTHER'S NAME (First, Middle, Maiden Surname) <b>KATHERINE BURK</b>			
27. INFORMANT'S NAME (Type/Print) <b>FRANK J. BOVA</b>				28. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>515 Dogwood Rd, Linthicum, MDD 21090</b>			
29. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		30. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>NEW CATHEDRAL CEMETERY 8-16</b>		31. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>		32. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Howard H. Hubbard</i>	
33. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Adenocarcinoma of the Lung</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST a. <b>with liver failure</b> b. <b>Due to (OR AS A CONSEQUENCE OF):</b> c. <b>Due to (OR AS A CONSEQUENCE OF):</b> d. <b>Due to (OR AS A CONSEQUENCE OF):</b>		34. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		35. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Approximate Interval Between Onset and Death <b>Approx 2 weeks</b>	
36. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>-</b>				37. 25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
38. 26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		39. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		40. 28a. DATE OF INJURY (Month, Day, Year) <b>-</b>		41. 28b. TIME OF INJURY <b>M</b>	
42. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		43. 28d. DESCRIBE HOW INJURY OCCURRED <b>-</b>		44. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>-</b>		45. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>-</b>	
46. 29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		47. 29b. SIGNATURE AND TITLE OF CERTIFIER <i>Dan H. Schreiber</i>		48. 29c. LICENSE NUMBER <b>D28221</b>		49. 29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>	
50. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DAN SCHREIBFEDER, M.D./301 HOSPITAL DRIVE/GLEN BURNIE, MARYLAND 21061</b>							
51. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		52. REGISTRAR'S SIGNATURE <i>John K. Riddle</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>EVELYN BECKER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>				3. TIME OF DEATH <b>5:00 PM</b>	
4. SOCIAL SECURITY NUMBER <b>214-01-3248</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03/22/10</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>St. Joseph's Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>TOWSON</b>				9c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Cockeysville</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>312 Cranbrook Rd.</b>				10f. ZIP CODE <b>21030</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>12th grade</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>	
17. FATHER'S NAME (First, Middle, Last) <b>John Mitchell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Hayden</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Eleanor Carlton</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>312 Cranbrook Rd. Cockeysville, Md.</b>					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Parkwood Cemetery</b>				20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lassahn Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Lassahn Funeral Home</b> <b>7401 Belair Rd. Balto., Md. 21236</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>ATRIAL FIBRILLATION</b> DUE TO (OR AS A CONSEQUENCE OF):  Approximate Interval Between Onset and Death <b>2 WEEKS</b>									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
				28d. DESCRIBE HOW INJURY OCCURED					
				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)					
				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Michael D. Presser, M.D.</b>				29c. LICENSE NUMBER <b>D 40547</b>	
				29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MICHAEL D. PRESSER, M.D., ST. JOSEPH'S HOSPITAL, 7620 YORK ROAD, TOWSON, MD 21204</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is checked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Meyer Blickstein</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug 7 91</b>		3. TIME OF DEATH <b>9-4</b>	
4. SOCIAL SECURITY NUMBER <b>216-32-6542</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>87</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-13-04</b>	
8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>				9a. FACILITY NAME (If not institution, give street and number) <b>8500 ALLENSWOOD RD.</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>RANDALLSTOWN</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>8500 ALLENSWOOD RD.</b>	
10f. ZIP CODE <b>21133</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2</b> College (1-4 or 5+) <b>College (1-4 or 5+)</b>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>FURRIER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>FUR</b>			
17. FATHER'S NAME (First, Middle, Last) <b>SOLOMON BLICKSTEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MIRIAM GERSHENSON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. SALLY BLICKSTEIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8500 ALLENSWOOD RD. RANDALLSTOWN, MD 21133</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH TFILOH 8/9/91</b>			
20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Day Alay Lewis</b>			
22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>PANCREATIC CARCINOMA</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Nomicide			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>Malachuk S. Dan &amp;</b>			
29c. LICENSE NUMBER <b>D 04193</b>				29d. DATE SIGNED (Month, Day, Year) <b>7 Aug 91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>1777 REISTERSTOWN RD, PIKEVILLE, MD 21208</b>				31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>			
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randell</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL HOME: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SYLVIA BAKER</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:43</b>	
4. SOCIAL SECURITY NUMBER <b>219-28-5072</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>88</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>may 6, 1903</b>	8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALLSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>7435 RICKSWAY RD.</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>usa</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify: <b>XX</b>		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>HOUSEWIFE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>AT HOME</b>			
17. FATHER'S NAME (First, Middle, Last) <b>MICHAEL ISAAC BLUM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MINNIE BLAUSTEIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. JUNE B. SHAPIRO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7435 RICKSWAY RD. BALTIMORE, MD 21208</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH TFILOH 8/11/91</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (First disease or condition resulting in death) → <b>Acute Myocardial Infarction</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i> M.D.				29c. LICENSE NUMBER <b>D19502</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-9-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ORLANDO B. CANTANU MD BCGH, RANDALLSTOWN MD, 21133</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>STEVEN L BERRY</b>				2. DATE OF DEATH 8 MONTH 11 DAY 1991 YEAR		3. TIME OF DEATH 9:16 P M	
4. SOCIAL SECURITY NUMBER 219 11 9259		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 17 YRS.		7. DATE OF BIRTH (Month, Day, Year) 10/1/73	
8. BIRTHPLACE (State or Foreign Country) LITTLE ROCK ARK				9a. FACILITY NAME (If not institution, give street and number) MARYLAND ROUTE I#197		9b. CITY, TOWN OR LOCATION OF DEATH BOWIE	
9c. COUNTY OF DEATH PRINCE GEORGE				10a. STATE MARYLAND		10b. COUNTY PRINCE GEORGE	
10c. CITY, TOWN OR LOCATION OXON HILL				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 7406 ABBINGTON DRIVE	
10f. ZIP CODE 20745				10g. CITIZEN OF WHAT COUNTRY? United states		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: BLACK				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) STUDENT			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) STUDENT				16b. KIND OF BUSINESS/INDUSTRY PUBLIC SCHOOLS			
17. FATHER'S NAME (First, Middle, Last) ALFRED BERRY				18. MOTHER'S NAME (First, Middle, Maiden Surname) JEANNETTE MARSHALL			
19a. INFORMANT'S NAME (Type/Print) ALFRED BERRY				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 7406 ABBINGTON DR OXON HILL MD 20745			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input checked="" type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) WILL ACKLIN F.H. 8/18			
20c. LOCATION — City or Town, State LITTLE ROCK ARK.				21. SIGNATURE OF FUNERAL SERVICE LICENSEE Alexander S. Pope, Jr.			
22. NAME AND ADDRESS OF FACILITY ALEXANDER S POPE FUNERAL HOME 2617 PA AVE SE WASH DC 20020				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. CHEST INJURIES DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO			
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) MARYLAND ROUTE				27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide			
28a. DATE OF INJURY (Month, Day, Year) 8-11-91				28b. TIME OF INJURY 9:00 PM			
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE NOW INJURY OCCURRED DRIVER IN AUTO/AUTO IMPACT			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) MARYLAND ROUTE				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) MARYLAND ROUTE I#197			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Donald G Wright MD			
29c. LICENSE NUMBER OCME				29d. DATE SIGNED (Month, Day, Year) 8-12-1991			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G WRIGHT, MD DCME 111 N. PENN STREET BALTIMORE, MARYLAND 2120				31. DATE FILED (Month, Day, Year) AUG 14 1991			
32. REGISTRAR'S SIGNATURE Julia Davidson-R...							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ANY OTHER PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: The law requires that the death certificate be signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>Tommie GORDON - CARTER</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:13 AM</b>	
4. SOCIAL SECURITY NUMBER <b>243 72 3652</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>41</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-20-50</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park Md.</b>	
9c. COUNTY OF DEATH <b>Montgomery</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>PG</b>	
10c. CITY, TOWN OR LOCATION <b>Largo,</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>10612 Mt. Lubentia Way</b>	
10f. ZIP CODE <b>20772</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United states</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2 years</b> College (1-4 or 5+) <b>Gov.</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Gov.</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Tommie Lee Sherrill, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Bertha Ruth Lockett</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Bertha Lockett</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>211 West Bradley Street Gastonia, N.C.</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input checked="" type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Park 8/17/91</b>		20c. LOCATION — City or Town, State <b>Landover, Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John T. Stewart III</b>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 4001 Benning Road, N.E.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic shock</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Cardiovascular failure</b> <b>Myocardial infarction</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Myocardial infarction</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>John T. Stewart III</b>		29c. LICENSE NUMBER <b>201449</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)			
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>John T. Stewart III</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEASED'S NAME (First, Middle, Last) <b>BLANCHE L. CHENOWETH</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 12 1991</b>		3. TIME OF DEATH M <b>1:52 A</b>	
4. SOCIAL SECURITY NUMBER <b>212-10-5071</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>84</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>JAN. 26, 1907</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>OLD COURT NURSING CENTER</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>517 S. LONGWOOD STREET</b>	
10f. ZIP CODE <b>21223</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th grade</b> College (1-4 or 5+) <b>PUBLIC RELATIONS</b>				16a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RETAIL SALES</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>EMORY S. HAYDEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ADA BELL</b>			
19a. INFORMANT'S NAME (Type/Print) <b>EMORY S. CHENOWETH</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5414 COUNCIL STREET, BALTIMORE, MD. 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Loudon Park Cemetery 8/14</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>M. Neal Coleman</i>				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Metastatic Esophageal Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Naeem Gauhar</i>				29c. LICENSE NUMBER <b>518326</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. NAEEM GAUHAR, 5400 OLD COURT ROAD, RANDALLSTOWN, MD. SUITE #105</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician to the FUNERAL DIRECTOR. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

SECRET 12

91 21923

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Betsy Carthen</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 9, 1991</b>				3. TIME OF DEATH <b>1:30 P M</b>	
4. SOCIAL SECURITY NUMBER <b>237-56-8988</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>85</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-9-91</b>		8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>140 W. LAFAYETTE AVE. GOLDEN TOUCH NURSING HOME</b>				10f. ZIP CODE <b>21217</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JESSIE ANNA McRAE</b>					
19a. INFORMANT'S NAME (Type/Print) <b>HARRY L. MC RAE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7404 MARSTON ROAD BALTO., MD. 21207</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>ARBUTUS MEM. PARK 8-14</b>		20c. LOCATION — City or Town, State <b>ARBUTUS, MD.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSE <i>Portia Chron</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH FUNERAL HOME 1300 WABASH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Myocardial Infarction</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST { a. DUE TO (OR AS A CONSEQUENCE OF): <b>Coronary Artery Disease</b> b. DUE TO (OR AS A CONSEQUENCE OF): <b>old age</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes Mellitus</b>								Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Anil UBEROI MD</i>		29c. LICENSE NUMBER <b>D 26748</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ANIL UBEROI, 3830 FALLS RD BALTO MD 21211</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4556-510

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FOR  
STATE  
1 - REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ANDERSON</b>				2. DATE OF DEATH <b>08<sup>TH</sup> 09<sup>DAY</sup> 1991<sup>AR</sup></b>				3. TIME OF DEATH <b>02:08 A<sup>M</sup></b>	
4. SOCIAL SECURITY NUMBER <b>242-62-6658</b>		5. SEX <b>1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F</b>		6. AGE (In yrs. last birthday) <b>49 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>11 19 41</b>		8. BIRTHPLACE (State or Foreign Country) <b>NORTH CAROLINA</b>	
9a. FACILITY NAME (If not Institution, give street and number) <b>HOME-3505 DEVONSHIRE DRIVE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO., CITY</b>				10d. INSIDE CITY LIMITS? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>	
10e. STREET AND NUMBER <b>3505 DEVONSHIRE DRIVE</b>				10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <b>1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married</b> <b>3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced</b>		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO</b> IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:</b>				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) College (1-4 or 5+)</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>ANDERSON CAISON SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MELISSA JOHNSON</b>					
19a. INFORMANT'S NAME (Type/Print) <b>LAVERNE CAISON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3505 DEVONSHIRE DRIVE BALTO., MD 21215</b>					
20a. METHOD OF DISPOSITION <b>1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State</b> <b>4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)</b>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEM. PARK 8-17</b>				20c. LOCATION — City or Town, State <b>RANDALLSTOWN</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Patricia Elron</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONTACT GUNSHOT WOUND OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF):									
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? <b>1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO</b>					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>XX YES 2 <input type="checkbox"/> NO</b>				26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA</b> OTHER: <b>4 <input checked="" type="checkbox"/> Nursing Home XX Residence 6 <input type="checkbox"/> Other (Specify)</b>					
27. MANNER OF DEATH <b>1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation</b> <b>2 <input type="checkbox"/> Accident 8 <input type="checkbox"/> Could not be determined</b> <b>3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide</b>				28a. DATE OF INJURY (Month, Day, Year) <b>08 09 1991</b>		28b. TIME OF INJURY <b>10:23 AM</b>		28c. INJURY AT WORK? <b>1 <input type="checkbox"/> YES XX NO</b>	
28d. DESCRIBE HOW INJURY OCCURRED <b>SELF INFLICTED GUNSHOT</b>				28e. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>HOME-3505 DEVONSHIRE DRIVE BALTIMORE CITY</b>					
29a. CERTIFIER (Check only one) <b>XX MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.</b>									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>OCME</b>				29d. DATE SIGNED (Month, Day, Year) <b>08 09 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD OCME 111 PENN STREET BALTIMORE, MARYLAND 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodella</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

JWR

21 51357

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Cecelia A. Cornelius</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:43A</b>	
4. SOCIAL SECURITY NUMBER <b>216-42-7274</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>47</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/14/44</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>University Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>md</b>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>321 Denison Street</b>	
10f. ZIP CODE <b>21229</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Arthur Thompson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lillian</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Nathaniel Cornelius</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>321 Denison St. Baltimore, md 21229</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem PK 8113th</b>		20c. LOCATION — City or Town, State <b>Baltimore, md</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Wesley Edmond</b>				22. NAME AND ADDRESS OF FACILITY <b>March-West 4300 Wabash ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Aspiration</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>GI Bleed</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Brain Tumor</b> <b>Diabetes mellitus</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Ann Shirey Hagen MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ann Shirey Hagen 22 S. Greene St. Baltimore MD 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





REG. NO.

DHMH-18 Rev 1/89

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES AUGUSTUS COOK</b> <b>CHARLES - A. COOK</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>09</b> YEAR <b>91</b>		3. TIME OF DEATH <b>6-50 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>214-01-7564</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-23-11</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>		9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>		9c. COUNTY OF DEATH <b>Howard</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>		10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>12260 Carroll Mill Road</b>				10f. ZIP CODE <b>21042</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8th</b> College (13-16) <b>5+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Electrician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Electrical</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Columbus Cook</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Josephine Louise Hamfmann</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Josephine Davis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>12260 Carroll Mill Rd., Ellicott City, MD 21042</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore-Washington Crem.</b>		20c. LOCATION — City or Town, State <b>Laurel, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John A. Slack</i> <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home Ellicott City, Maryland 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio Pulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Cardiomyopathy &amp; Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Peripheral Vascular Disease</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>D. B. Vellanki</i> ( <b>VELLANKI</b> )				29c. LICENSE NUMBER <b>D.30469</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-9-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>ROSS, CHEVROLET DRIVE # 101: Ellicott City: MD. 21042</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51254

91 21928

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Thelma Conner</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>04</b> YEAR <b>91</b>				3. TIME OF DEATH <b>1215 A</b> M			
4. SOCIAL SECURITY NUMBER <b>220-30-2570</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>81</b> YRS.		IF UNDER 1 YEAR MONTHS _____ DAYS _____		IF UNDER 24 HRS. HOURS _____ MIN. _____			
7. DATE OF BIRTH (Month, Day, Year) <b>08-17-1909</b>				8. BIRTHPLACE (State or Foreign Country) <b>North Carolina</b>				9. COUNTY OF DEATH <b>Harford</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Harford Memorial Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Harford</b>				9c. COUNTY OF DEATH <b>Harford</b>			
10a. STATE <b>Maryland</b>			10b. COUNTY <b>Baltimore</b>			10c. CITY, TOWN OR LOCATION <b>Owings Mills</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>107 Willow Bend Drive</b>						10f. ZIP CODE <b>21117</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>2+</b> College (1-4 or 5+) <b>2+</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Nursing</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Hospital</b>				
17. FATHER'S NAME (First, Middle, Last) <b>George Hassell</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>unknown</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Frances Colt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2271 Baldwin Mill Rd., Fallston, MD 21047</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>New Cathedral Cemetery 8/6 Baltimore, MD</b>			20c. LOCATION — City or Town, State				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John H. Slack</b> M00535				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home Ellicott City, Maryland 21043</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cerebro Vascular Accident</b> a. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate interval Between Onset and Death <b>9 days</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M _____		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William M.D.</b>						29c. LICENSE NUMBER <b>D 32609</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/4/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>KAMPUDIN MITHANI MD 703 Revolution St. Harro De Grace MD 21078</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51359

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This form requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21929

1. DECEDENT'S NAME (First, Middle, Last) David Nathaniel Cosby				2. DATE OF DEATH MONTH DAY YEAR August 11 1991		3. TIME OF DEATH 4:15 A M	
4. SOCIAL SECURITY NUMBER 227-10-3797		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 90 YRS.		7. DATE OF BIRTH (Month, Day, Year) August 09/01 Virginia	
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH none	
10a. STATE Maryland		10b. COUNTY none		10c. CITY, TOWN OR LOCATION Baltimore City		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 730 Asburton Avenue		10f. ZIP CODE 212		10g. CITIZEN OF WHAT COUNTRY? United States			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: NEGROID	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 6th grade		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Salesman/truckdriver		16b. KIND OF BUSINESS/INDUSTRY Capt. Hubert Seafood			
17. FATHER'S NAME (First, Middle, Last) Peter T. Cosby				18. MOTHER'S NAME (First, Middle, Maiden Surname) Emily Robinson			
19a. INFORMANT'S NAME (Type/Print) Allen Cosby				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 5770 Maple Hill Road, Balto, Md.			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Baltimore Cemetery		20c. LOCATION — City or Town, State Baltimore, Maryland			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>		22. NAME AND ADDRESS OF FACILITY Calvin B. Scruggs Funeral Home 412 E. Preston St. Balto, Md. 21213					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sepsis Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Cancer Of The Pancreas b. DUE TO (OR AS A CONSEQUENCE OF): Obstructive Jaundice c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide					
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER CHEUNG M.D.				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) 8/11/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Cheung Chhieng, M.D. C/O Maryland General Hospital 827 Linden Avenue							
31. DATE FILED (Month, Day, Year) AUG 14 1991		32. REGISTRAR'S SIGNATURE <i>Juha Davidson-Randall</i>					

01 51253



91 21930

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR DEARING</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 10, 1991</b>		3. TIME OF DEATH M <b>11:15A</b>	
4. SOCIAL SECURITY NUMBER <b>224-32-1447</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>71</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6-16-20</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE CITY</b>	
10a. STATE <b>MD</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>823 RUTLAND AVENUE</b>		10f. ZIP CODE <b>21205</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>				11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7TH</b> College (1-4 or 5+) <b>CONTRACTOR</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CONTRACTOR</b>				16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>JOHN DEARING</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LIZEA JETT</b>				19a. INFORMANT'S NAME (Type/Print) <b>MARIE LOWERY</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>823 RUTLAND AVE./BALTIMORE, MD 21205</b>	
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>VOSHELL MEM. GARDENS CEM.</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Lynette K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIORESPIRATORY ARREST</b>  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>CONGESTIVE HEART FAILURE</b> <b>HYPERTENSION</b> <b>SEIZURE DISORDER</b>	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28. PLACE OF INJURY (Month, Day, Year) <b>28a. DATE OF INJURY</b> <b>28b. TIME OF INJURY</b> <b>28c. INJURY AT WORK?</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>28d. DESCRIBE HOW INJURY OCCURRED</b>	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>STUART</i> MD		29c. LICENSE NUMBER <b>D17131</b>	
29d. DATE SIGNED (Month, Day, Year) <b>12 AUG 91</b>				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GODOFREDO U. STUART JR 1000 EAGER ST BALTO MD 21202</b>		31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>	
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randell</i>				33. DATE OF DEATH <b>11:15A</b>		34. TIME OF DEATH <b>11:15A</b>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 51230

CARDIO RESPIRATORY

DISORDERS  
OF THE  
RESPIRATORY SYSTEM  
AND HEART FAILURE

W.D.  
EVEN

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21931									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN DELGADO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08/ 11/ 1991</b>				3. TIME OF DEATH <b>12:04 P M</b>									
4. SOCIAL SECURITY NUMBER <b>262-58-1268</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>64</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <b>1-20-27</b>		8. BIRTHPLACE (State or Foreign Country) <b>PUERTO RICO</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>THE JOHNS HOPKINS HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>									
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO									
10e. STREET AND NUMBER <b>1618 N. REGISTER STREET</b>				10f. ZIP CODE <b>21213</b>				10g. CITIZEN OF WHAT COUNTRY? <b>Puerto Rico</b>									
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Puerto Rican</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 6TH</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Janitor</b>		15b. KIND OF BUSINESS/INDUSTRY <b>MARYLAND WORKSHOP FOR BLIND</b>													
17. FATHER'S NAME (First, Middle, Last) <b>Juan Alberto Delgado</b>				16. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IEFFIE FANIA RIVERA</b>													
19a. INFORMANT'S NAME (Type/Print) <b>BETTY DELGADO</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1618 N. REGISTER STREET/BALTO., MD 21213</b>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, etc.) <b>KING MEMORIAL PARK CEM.</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD</b>													
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Glady Wane</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Pulmonary Emboli</b> <b>Salmonella Sporo</b> <b>Esophageal Varices</b> <b>Atherosclerosis</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> <b>Pancreatitis</b> <b>Duodenal Ulcer</b>												Approximate Interval Between Onset and Death <b>7/31/91</b> <b>7/31/91</b> <b>5/90</b> <b>1970</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Pancreatitis</b> <b>Duodenal Ulcer</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)													
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED									
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)													
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <b>Linda Mundy MD</b>		29c. LICENSE NUMBER <b>PENDING</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Linda Mundy - Johns Hopkins Hospital</b>																	
31. DATE FILED (Month, Day, Year) <b>8/14/91</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>													

at 51231

91 21932

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William S. C. Dolan</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>01:05A</b>	
4. SOCIAL SECURITY NUMBER <b>128-14-0442</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>Nov. 13, 1911</b>	
8. BIRTHPLACE (State or Foreign Country) <b>New Jersey</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Howard County General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Columbia</b>	
9c. COUNTY OF DEATH <b>Howard</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Howard</b>	
10c. CITY, TOWN OR LOCATION <b>Ellicott City</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>3000 Health Park</b>	
10f. ZIP CODE <b>21043</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5 +</b> College (1-4 or 5+) <b>5 +</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Physician</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Medical</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Charles Dolan</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Egan</b>			
19a. INFORMANT'S NAME (Type/Print) <b>McLaughlin Funeral Home</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>625 Pavonia Avenue Jersey City, New Jersey 07306</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Holy Rood Cemetery 8/16/91 Westbury, New York</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Michael Buck</i>				22. NAME AND ADDRESS OF FACILITY <b>Baltimore, Maryland Leonard J. Ruck, Inc. 5305 Harford Road 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. SEPSIS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. ATRIAL FIBRILLATION, SICK SINUS SYNDROME</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c. URINARY TRACT INFECTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. SEVERE ANEMIA</b> Approximate interval Between Onset and Death <b>6 hours</b> <b>3 months</b> <b>24 hours</b> <b>24 hours</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO						25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)						27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)						28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Joseph Gibbons, MD</i>						29c. LICENSE NUMBER <b>D38296</b>	
29d. DATE SIGNED (Month, Day, Year) <b>08-13-91</b>						30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH GIBBONS, MD. 9501 OLD ANNAPOLIS ROAD ELLICOTT CITY, MD 21042</b>	
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>						32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>	

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR. ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 31225

91-4627-055

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>LESLIE SCOTT DEICKMAN</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 13 1991</b>		3. TIME OF DEATH <b>2:45 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>216-08-3721</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>22</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>10-21-1968</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>7604 EASTERN AVENUE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7604 Eastern Ave.</b>	
10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12 Yrs.</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Installer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>A.T. &amp; T.</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Leslie L. Deickman, Jr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Jean M. Scott</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Leslie L. Deickman, Jr.</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7604 Eastern Ave., Balto., Md. 21224</b>			
20. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Moreland Memorial Cem. 8-17-91</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Roy H. Cather</b> <i>Roy H. Cather</i>				22. NAME AND ADDRESS OF FACILITY <b>Leonard J. Ruck, Inc., 5305 Harford Rd., Balto., Md. 21214</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. CONTACT GUNSHOT WOUND OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. 24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b>08/13/1991</b>		28b. TIME OF INJURY <b>2:45 a.m.</b>	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT SELF</b>			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>PRIVATE RESIDENCE</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>7604 EASTERN AVE., BALTIMORE, MARYLAND</b>			
29. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mario F. Golle, Jr.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/13/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE, JR., MD 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE OF DEATH (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Decker-Russell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be attached to it as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21934

1. DECEDENT'S NAME (First, Middle, Last) <b>Luvonia Duncan</b>		2. DATE OF DEATH MONTH DAY YEAR <b>08-11-91</b>		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER	5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>75</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) <b>3-16-1916</b>
8. BIRTHPLACE (State or Foreign Country) <b>Virginia</b>		9. COUNTY OF DEATH		
9a. FACILITY NAME (If not institution, give street and number) <b>2037 Wheeler Avenue</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE <b>MD.</b>	10b. COUNTY	10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
10e. STREET AND NUMBER <b>2037 Wheeler Avenue</b>		10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Retired</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Sales</b>		
17. FATHER'S NAME (First, Middle, Last) <b>Thornton Duncan</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Evelyn Stokes</b>		
19a. INFORMANT'S NAME (Type/Print) <b>Levon W. Ghee</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1924 W. Lexington St. Balto., MD. 21223</b>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Arbutus Mem. Park 8-15-91</b>		20c. LOCATION — City or Town, State <b>Balto., MD.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Douglas Hector</b>		22. NAME AND ADDRESS OF FACILITY <b>E.L. Phillips F/H 1721-27 N. Monroe St. Balto., MD. 21217</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic lung cancer</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		27. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	28d. DESCRIBE HOW INJURY OCCURRED
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Simon Bordin</b>		29c. LICENSE NUMBER <b>025675</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-14-91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Simon Bordin Rotunda Suite 400 701 W. 40th St Balto Md 21211</b>				
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Pendall</b>		

at 51334

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91 21935

91-4538-510

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>William G. Davis</i>				2. DATE OF DEATH MONTH DAY YEAR 08 08 1991		3. TIME OF DEATH 9:15 AM	
4. SOCIAL SECURITY NUMBER 217-15-6861		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 16 YRS.	7. DATE OF BIRTH (Month, Day, Year) 10-29-74		8. BIRTHPLACE (State or Foreign Country) MARYLAND	
9a. FACILITY NAME (If not institution, give street and number) Foot path in Leakin Park 4000 blk Clifton Avenue				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore		9c. COUNTY OF DEATH	
10a. STATE MARYLAND		10b. COUNTY		10c. CITY, TOWN OR LOCATION BALTIMORE, CITY		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER 4215 LIBERTY HEIGHTS AVE.				10f. ZIP CODE 21207		10g. CITIZEN OF WHAT COUNTRY? U.S.A.	
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) WILLIAM DAVIS				18. MOTHER'S NAME (First, Middle, Maiden Surname) ADELE W. FENNELI			
19a. INFORMANT'S NAME (Type/Print) DEBRA CHAPLIN				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4215 LIBERTY HEIGHTS AVE. BALTO., MD. 21207			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) ARBUTUS MEM. PARK		DATE 8-14		20c. LOCATION — City or Town, State ARBUTUS. MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Ebron</i>				22. NAME AND ADDRESS OF FACILITY WM.C. MARCH FUNERAL HOME 4300 WABASH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <i>SHOTGUN WOUNDS ABDOMEN, STAB WOUNDS OF NECK</i> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. DUE TO (OR AS A CONSEQUENCE OF):					
		c. DUE TO (OR AS A CONSEQUENCE OF):					
		d. DUE TO (OR AS A CONSEQUENCE OF):					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) Woods		24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) 08 08 1991		28b. TIME OF INJURY Found 9:05a M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) Unknown		28e. DESCRIBE HOW INJURY OCCURRED Subject shot and stabbed			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) Unknown					
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER O.C.M.E.		29d. DATE SIGNED (Month, Day, Year) 08 09 1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT MD 111 Penn Street, Baltimore Maryland 21201							
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 51632

ITEMS:23 thru 28f per ME  
G-679 9/6/91 cm

91-4477-027

FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21936

1. DECEDENT'S NAME (First, Middle, Last) Paul A. Durham				2. DATE OF DEATH MONTH 08 DAY 03 YEAR 1991		3. TIME OF DEATH 10:10 PM					
4. SOCIAL SECURITY NUMBER 216-08-7463		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 21 YRS.		7. DATE OF BIRTH (Month, Day, Year) 09-13-1969		8. BIRTHPLACE (State or Foreign Country) Maryland			
9a. FACILITY NAME (If not institution, give street and number) HARLESS FARM ROAD				9b. CITY, TOWN OR LOCATION OF DEATH WEST FRIENDSHIP			9c. COUNTY OF DEATH HOWARD				
10a. STATE Maryland		10b. COUNTY Howard County		10c. CITY, TOWN OR LOCATION Ellicott City			10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				
10e. STREET AND NUMBER 10439 Frederick Road				10f. ZIP CODE 21043		10g. CITIZEN OF WHAT COUNTRY? USA					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: White				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 11th College (1-4 or 5+) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) laborer			16b. KIND OF BUSINESS/INDUSTRY self-employed						
17. FATHER'S NAME (First, Middle, Last) Marvin Andrew Durham				18. MOTHER'S NAME (First, Middle, Maiden Surname) Lillie Bell Hensley							
19a. INFORMANT'S NAME (Type/Print) Verna Jenkins				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10439 Frederick Road, Ellicott City, MD 21043							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Crestlawn Mem. Gdns. 8/8		20c. LOCATION — City or Town, State Marriottsville, MD							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Keller</i> M00535				22. NAME AND ADDRESS OF FACILITY Slack Funeral Home Ellicott City, Maryland 21043							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. GUNSHOT WOUND OF HEAD DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input checked="" type="checkbox"/> Other (Specify) ROAD									
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input checked="" type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) UNKNOWN		28b. TIME OF INJURY UNKNOWN		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED SELF INFLICTED GUNSHOT WOUND			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER OCME		29d. DATE SIGNED (Month, Day, Year) 08-04-1991	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) DONALD G. WRIGHT, MD, OCME 111 N. PENN STREET BALTIMORE, MARYLAND 21201											
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91-4626-033

91 21937

F.E.H.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>CLIFFORD H. DRIVERS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>14:10</b> M	
4. SOCIAL SECURITY NUMBER <b>158-28-0691</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>53</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-19-1938</b>	
8. BIRTHPLACE (State or Foreign Country) <b>N.J.</b>		9a. FACILITY NAME (If not institution, give street and number) <b>LELAND MEMORIAL HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>RIVERDALE</b>		9c. COUNTY OF DEATH <b>PRINCE GEORGES</b>	
10a. STATE <b>NJ</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Newark</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>843 S. 13th St</b>		10f. ZIP CODE <b>07108</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>May 51 - May 77</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12th</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Car Carrier</b>		16b. KIND OF BUSINESS/INDUSTRY <b>M+G Convoy Co.</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Clifford H. Drivers</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Lelia Bumpers</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Estelle Drivers</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>843 S. 13th St Newark, N.J. 07108</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Glendale Cemetery 8/17/91</b>		20c. LOCATION — City or Town, State <b>Bloomfield, N.J.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Derrick C. Jones</b>				22. NAME AND ADDRESS OF FACILITY <b>Derrick C. Jones F.H. Baltimore, MD 21215 4611 Park Heights Ave</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASCVD</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>6</b> <input type="checkbox"/> Could not be determined <b>3</b> <input type="checkbox"/> Suicide <b>8</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Stennis J. Chute MD</b>				29c. LICENSE NUMBER <b>O. C. M. E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>AUGUST 13, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>J. H. Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the certificate be completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JEAN DEARING</b>				2. DATE OF DEATH MONTH <b>8</b> - DAY <b>11</b> - YEAR <b>91</b>		3. TIME OF DEATH <b>8:09 AM</b>	
4. SOCIAL SECURITY NUMBER <b>215-44-1472</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>78</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>OCT. 6, 1912</b>	
8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>				9a. FACILITY NAME (If not institution, give street and number) <b>106 SACRED HEART LANE</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>REISTERSTOWN</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>	
10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>7924 DUNHILL VILLAGE CIR., APT. 103</b>	
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		16b. KIND OF BUSINESS/INDUSTRY <b>DEPT. OF SOCIAL SERVICES</b>	
17. FATHER'S NAME (First, Middle, Last) <b>JOSEPH KLEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARAH COHEN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. BEVERLY STUCK</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>106 SACRED HEART LANE REISTERSTOWN, MD 21136</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>RODFE ZEDEK 8/12/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joel D Lewis</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic breast CA</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)	
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John H. Alston</i>				29c. LICENSE NUMBER <b>D-20882</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>JOSEPH O. CASSAN</i>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed in the office of the Registrar of the Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21939

1. DECEDENT'S NAME (First, Middle, Last) <b>NANNIE P. FOWLER</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>6:15 A M</b>	
4. SOCIAL SECURITY NUMBER <b>216-24-8107</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>1-25-28</b>		8. BIRTHPLACE (State or Foreign Country) <b>N.C.</b>		9. CITY, TOWN OR LOCATION OF DEATH <b>100 N Broadway Balto</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Fairmont Mx Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>100 N Broadway Balto</b>		9c. COUNTY OF DEATH <b>N.C.</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTO., CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTO., CITY</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>924 N. PAYSON ST.</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE YEAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		17. FATHER'S NAME (First, Middle, Last) <b>JAMES FRED BUTLER</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>VIRETTA FOWLER</b>		19a. INFORMANT'S NAME (Type/Print) <b>EARLENE HUBBARD</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1622 LLEWELYN AVE. BALTO., MD. 21213</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD. NATIONAL MEM. PARK 8-15 LAUREL, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Ebron</b>	
22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>HEMORRAGIC LUNG CA</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28f. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph Quint</b>		29c. LICENSE NUMBER <b>D 40903</b>	
29d. DATE SIGNED (Month, Day, Year) <b>AUG 14 1991</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>JOSEPH QUINT, CHURCH HSE, 400 BROADWAY, BALTO MD</b>		31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>	
32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Rendell</b>					

2019 14

91 21940

FEH

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NORRIS FRANCIS</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>16:10 P M</b>			
4. SOCIAL SECURITY NUMBER <b>012-87-7428</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <b>2</b> <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>27</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-3-1964</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SHOCK TRAUMA/UNIVERSITY HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH			
10a. STATE <b>MD</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>			
10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>4722 ALHAMBRA AVENUE</b>					
10f. ZIP CODE <b>21212</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>					
11. MARITAL STATUS <b>1</b> <input type="checkbox"/> Never Married <b>2</b> <input checked="" type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <b>4</b> <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yee or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (9-12)</b> <b>12TH</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>FRANK FRANCIS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>RUTHLYN</b>					
19a. INFORMANT'S NAME (Type/Print) <b>PRINCESS FRANCIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4722 ALHAMBRA AVE./BALTIMORE, MD 21212</b>					
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <b>2</b> <input type="checkbox"/> Cremation <b>3</b> <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place) <b>BALTIMORE CEM. Woodlawn Cem.</b>		DATE		20c. LOCATION — City or Town, State <b>Baltimore, Md.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Calvin L. Williams</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. MULTIPLE GUNSHOT WOUNDS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input checked="" type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input type="checkbox"/> Residence <b>8</b> <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <b>1</b> <input type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>4</b> <input checked="" type="checkbox"/> Homicide <b>6</b> <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>8-8-91</b>		28b. TIME OF INJURY <b>14:28 M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT SHOT MULTIPLE TIMES</b>	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOUSE-INSIDE</b>				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>2609 ROSALYN AVE. BALTO., MD.</b>					
29a. CERTIFIER (Check only one) <b>1</b> <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Donald G. Wright MD</b>				29c. LICENSE NUMBER <b>O. C. M. E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-9-1991</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD DCME 111 PENN STREET BALTIMORE, MARYLAND 21201</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 11:00

91 21941

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ARTHUR E. FINDLING</b>				2. DATE OF DEATH <b>August 12, 1991</b>		3. TIME OF DEATH <b>5:25 A.</b>	
4. SOCIAL SECURITY NUMBER <b>214-42-3264</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>47</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Sept. 3, 1943</b>	8. BIRTHPLACE (State or Foreign Country) <b>Washington, D. C.</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>13 Sherman Avenue</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>Maryland</b>				10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Takoma Park</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							
10e. STREET AND NUMBER <b>13 Sherman Avenue</b>				10f. ZIP CODE <b>20912</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Owner</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Construction Management Business &amp; Design</b>			
17. FATHER'S NAME (First, Middle, Last) <b>David P. Findling</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Natalie J. Trustman</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Robert M. Findling</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2233 Calle Cacique Santa Fe, New Mexico 87505</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>King David Memorial Garden</b>		20c. LOCATION — City or Town, State <b>Falls Church, Virginia</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Donald C. Stettinmyer</b>				22. NAME AND ADDRESS OF FACILITY <b>Stein Hebrew Memorial Funeral Home, Inc. 232 Carroll Street, N.W., Washington, D. C.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>metastatic melanoma</b> DUE TO (OR AS A CONSEQUENCE OF): a. _____ b. _____ c. _____ d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate interval Between Onset and Death <b>18 mo.</b>
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>James H. Brodsky</b>				29c. LICENSE NUMBER <b>D-20297</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 12, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>James H. Brodsky, M. D. 4701 Willard Avenue, Suite # 224, Chevy Chase, Md 20815</b>							
31. DATE FILED (Month, Day, Year) <b>Aug 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN—MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: This certificate requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 26 is marked, or item 27 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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91 21942

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>KATHRYN MAE FRAZIER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>8 11 1991</b>		3. TIME OF DEATH <b>11:23 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>220-21-8190</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>2 YRS.</b>		7. DATE OF BIRTH (Month, Day, Year) <b>9-6-1988</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>JOHNS HOPKINS HOSPITAL</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>	
9c. COUNTY OF DEATH <b>-----</b>				10a. STATE <b>MARYLAND</b>			
10b. COUNTY <b>HOWARD COUNTY</b>				10c. CITY, TOWN OR LOCATION <b>ELKRIDGE</b>			
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>8126 FOREVER GREEN COURT</b>			
10f. ZIP CODE <b>21227</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>0</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>UNEMPLOYED</b>		16b. KIND OF BUSINESS/INDUSTRY <b>N/A</b>			
17. FATHER'S NAME (First, Middle, Last) <b>NELSON BRUCE FRAZIER</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LORI JEAN PELLEGRINO</b>			
19a. INFORMANT'S NAME (Type/Print) <b>NELSON B. FRAZIER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8126 FOREVER GREEN CT., ELKRIDGE, MD 21227</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Meadowridge Mem. Pk. 8/15</b>		20c. LOCATION — City or Town, State <b>Elkridge, MD</b>		20d. DATE <b>8/15</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John Slack</i> <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>SLACK Funeral Home Ellicott City, Maryland 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. MULTIPLE INJURIES OF HEAD</b> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>24a. WAS AN AUTOPSY PERFORMED?</b> 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO <b>24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?</b> 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input checked="" type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8-11-91</b>		28b. TIME OF INJURY <b>10:31</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>SUBJECT STRUCK BY AUTO</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME-DRIVEWAY</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>8126 FOREVER GREEN CT.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>O. C. M. E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08-12-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT, MD DCME 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rodriguez</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

01 5145



01 51943

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21944

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTIE BARNETT</b>		2. DATE OF DEATH MONTH <b>AUG</b> DAY <b>12</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>3:40 P M</b>	
4. SOCIAL SECURITY NUMBER <b>219-18-4326</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>77</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>1-13-14</b>		8. BIRTHPLACE (State or Foreign Country) <b>S.C.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>PLEASANT MANOR NURSING HOME</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>	
10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4615 PARK HEIGHTS AVENUE</b>		10f. ZIP CODE <b>21215</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (1-4 or 5+) <b>DOMESTIC</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOMESTIC</b>		17. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM MARTIN</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ALMA LOWE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VERLEA HARDING</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6649 WYCOMB WAY/BALTIMORE, MD 21234</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>		20c. LOCATION — City or Town, State <b>CATONSVILLE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Glenn Warner</b>		22. NAME AND ADDRESS OF FACILITY <b>WM.C.MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Adenocarcinoma of stomach</b>  Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Arteriosclerotic Heart Disease &amp; Congestive Heart Failure</b> <b>hypertension with renal insufficiency</b> <b>Diabetes mellitus</b>		Approximate Interval Between Onset and Death <b>1 year</b> <b>6 months</b> <b>3 years</b> <b>5 years</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <b>Manuel Levin MD</b>		29c. LICENSE NUMBER <b>006522</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MANUEL LEVIN, MD. 6101 PK HOTSAVE BALTO MD 21215</b>			
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>Johia Davidson-Rendell</b>			

Page 10

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21945	
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH	
HATTIE L. GRANT				AUGUST 11, 1991				3:45 a	
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (in yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)	
212-22-3691		1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		75 YRS.		Feb. 15, 1916		S. Carolina	
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
THE JOHNS HOPKINS HOSPITAL				BALTIMORE CITY				BALTIMORE CITY	
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?	
Maryland				Baltimore				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
2536 Harford Road				21218		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.)		14. RACE — American Indian, Black, White, etc. Specify:			
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY					
Elementary/Secondary (0-12) College (1-4 or 5+)		Laborer - Retired		Domino Sugar					
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
Jacob Jones				Emma Davis					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
LaBrenda Butler				619 East 38th Street, Balto. MD 21218					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		Garrison Forest Vets		8/16		Garrison, MD			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
<i>Blanca Adams Jones</i>				Marshall W. Jones Jr, Funeral Home PA 4101 Edmondson Avenue, Balto. MD 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Malignant melanoma</i>								3 yrs.	
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
b. DUE TO (OR AS A CONSEQUENCE OF):									
c. DUE TO (OR AS A CONSEQUENCE OF):									
d. DUE TO (OR AS A CONSEQUENCE OF):									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
<i>metastases to brain, lungs, bone.</i>									
24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one)									
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
<i>Patty Lee MD</i>				JSD/B		8/11/91			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
Johns Hopkins Hospital Baltimore									
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE							
AUG 14 1991		<i>Julia Davidson-Rendell</i>							

21 5142



91 21946

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Frances A. Gervas				2. DATE OF DEATH MONTH DAY YEAR 8-12-1991				3. TIME OF DEATH 7:15 P M	
4. SOCIAL SECURITY NUMBER 215-12-9736		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 67 YRS.		7. DATE OF BIRTH (Month, Day, Year) 11-26-1923		8. BIRTHPLACE (State or Foreign Country) Maryland	
9a. FACILITY NAME (If not institution, give street and number) 1000 Upnor Rd.				9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City				9c. COUNTY OF DEATH ---	
10a. STATE Md.		10b. COUNTY ---		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 1000 Upnor Road				10f. ZIP CODE 21212		10g. CITIZEN OF WHAT COUNTRY? U.S.A.			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) Unknown College (1-4 or 5+) College				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker				16b. KIND OF BUSINESS/INDUSTRY Own Home	
17. FATHER'S NAME (First, Middle, Last) Anthony Messina				18. MOTHER'S NAME (First, Middle, Maiden Surname) Rosalie ? unknown					
19a. INFORMANT'S NAME (Type/Print) Paul Gervas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 1000 Upnor Rd., Balto., Md. 21212					
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Most Holy Redeemer Cem. 8-14-91 Balto., Md.				20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Roland P. Stauch MO0550				22. NAME AND ADDRESS OF FACILITY Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Dundalk, Md. 21222					
23. PART I. Enter the disease, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Metastatic Spidermoid Lung Cancer</u> DUE TO (OR AS A CONSEQUENCE OF): Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <u>Uremia</u>								Approximate Interval Between Onset and Death ~ 2 1/2 yrs.	
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER Paul Chang				29c. LICENSE NUMBER D16587				29d. DATE SIGNED (Month, Day, Year) 8/13/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Paul Chang, MD 5601 Loch Raven Blvd, Baltimore, Maryland 21239									
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE John Davidson-Rendell					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.



91 21947

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Herman Graham</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1:05 P M</b>	
4. SOCIAL SECURITY NUMBER <b>230 42 1351</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09/19/32</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Carolina</b>							
9a. FACILITY NAME (If not institution, give street and number) <b>4521 East-West Highway Apt. 602</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Bethesda</b>		9c. COUNTY OF DEATH <b>Montgomery</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>MONTGOMERY</b>		10c. CITY, TOWN OR LOCATION <b>BETHESDA</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4521 East West Highway #602</b>				10f. ZIP CODE <b>20814</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Car Salesman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIE GRAHAM</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>ELIZABETH BROOKS</b>			
19a. INFORMANT'S NAME (Type/Print) <b>THELMA WHITE (SISTER)</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>9610 Wedgewood Drive, Oxon Hill, Md. 20744</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Harmony Memorial Cemetery 8/15</b>		20c. LOCATION — City or Town, State <b>Landover, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Alex S. Pope Jr.</i> <b>M859</b>				22. NAME AND ADDRESS OF FACILITY <b>ALEXANDER S. POPE FUNERAL HOME 2617 Pennsylvania Avenue, SE DC 20020</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>e. Exsanguination</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>8-8-91</b>		28b. TIME OF INJURY <b>Found 1:05P</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>Home</b>		28e. DESCRIBE HOW INJURY OCCURRED <b>Subject Cut Self (Foot)</b>			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>August 9, 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Donald G. Wright M.D. 111 Penn St. Baltimore, Md. 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After the certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51473

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11/11/11

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Suzie Hall</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>12</i> YEAR <i>91</i>		3. TIME OF DEATH <i>9:55 AM</i>	
4. SOCIAL SECURITY NUMBER <i>220074598</i>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>88</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>8/28/02</i>	
8. BIRTHPLACE (State or Foreign Country) <i>Namsemond, Va.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>Sinai Hosp Baltimore</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Balt City</i>	
9c. COUNTY OF DEATH				10. RESIDENCE OF DECEDENT			
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Balt, City</i>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <i>2508 Allendale St</i>				10f. ZIP CODE <i>21216</i>		10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>Meridith Goodman</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Betty Sue Goodman</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Bertha Goodman</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>2908 Allendale Ave. Balto, Md. 21216</i>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Woodlawn Cemetery</i>		DATE		20c. LOCATION — City or Town, State <i>Woodlawn, Md.</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <i>Leroy O. Dyett &amp; Son Funeral Home 4600 Liberty Heights Avenue 21207</i>			
23. PART I. Enter the diagnoses, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Heart Multiorgan system failure lwb</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Lung/Resp failure</i> DUE TO (OR AS A CONSEQUENCE OF): c. <i>Renal failure</i> DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <i>Sinai</i>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <i>5/30/99</i>		28b. TIME OF INJURY <i>M</i>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED <i>Strangled by her neck</i>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <i>Home</i>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Leroy O. Dyett MD</i>					
		29c. LICENSE NUMBER <i>#1886</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/12/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Dr. Sinai Hospital, Baltimore MD 21208</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 14 1991</i>		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit to be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

21 21040

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JULIUS HOLMES</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH M <b>1</b>	
4. SOCIAL SECURITY NUMBER <b>215-05-4524</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3/5/1908</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CARROLL COUNTY GENERAL HOSP.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE COUNTY</b>		9c. COUNTY OF DEATH <b>BALTO., MD</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE CITY</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1510 W. MOSHER ST.</b>				10f. ZIP CODE <b>USA</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>1944-1946</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ANDREW HOLMES</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>DORA GARRETT</b>			
19a. INFORMANT'S NAME (Type/Print) <b>LORETTA LASSITER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7019 ROCKRIDGE ROAD BALTIMORE, MD 21207</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garrison Forest Vet. Cem.</b>		20c. LOCATION — City or Town, State <b>Owings Mills, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>		22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ischemic cardiomyopathy</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>chronic renal failure hematuria</b>						Approximate Interval Between Onset and Death <b>years</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hasan H Babaturk</i>				29c. LICENSE NUMBER <b>D37592</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>HASAN BABATURK . 31 Clearlake Ct Baltimore MD 21234</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) EDWARD AARON HOGSTON				2. DATE OF DEATH MONTH DAY YEAR 08 13 91		3. TIME OF DEATH 10:00 A M	
4. SOCIAL SECURITY NUMBER 228-14-8412		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 2/28/1918	
8. BIRTHPLACE (State or Foreign Country) VA				9. FACILITY NAME (If not institution, give street and number) ST. AGNES HOSPITAL			
10. CITY, TOWN OR LOCATION OF DEATH BALTIMORE CITY				11. COUNTY OF DEATH BALTIMORE			
12. RESIDENCE OF DECEASED				13. STATE OF DEATH MARYLAND			
14. CITY, TOWN OR LOCATION BALTIMORE				15. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
16. STREET AND NUMBER 401 FONT HILL AVENUE				17. ZIP CODE 21223		18. CITIZEN OF WHAT COUNTRY? USA	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: WHITE	
23. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 7th grade College (1-4 or 5+) College				24. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) CHIEF CUSTODIAN		25. KIND OF BUSINESS/INDUSTRY BALTO.CO. BOARD OF EDUCATION	
26. FATHER'S NAME (First, Middle, Last) THEODORE HOGSTON				27. MOTHER'S NAME (First, Middle, Maiden Surname) BETTY DOANE			
28. INFORMANT'S NAME (Type/Print) VERA HOGSTON				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 401 FONT HILL AVE, BALTIMORE, MD. 21223			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) GOOD SHEPHERD CEMETERY		32. DATE 8-15		33. LOCATION — City or Town, State ELLCOTT CITY, MD	
34. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>James P. Smith</i>				35. NAME AND ADDRESS OF FACILITY HOWARD H. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD 21229			
36. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <u>Pneumonia</u> DUE TO (OR AS A CONSEQUENCE OF): b. <u>Stroke</u> DUE TO (OR AS A CONSEQUENCE OF): c. _____ DUE TO (OR AS A CONSEQUENCE OF): d. _____ Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. _____							
38. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				39. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO				41. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
42. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		43. DATE OF INJURY (Month, Day, Year) _____		44. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		45. DESCRIBE HOW INJURY OCCURRED _____	
46. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) _____		47. LOCATION (Street and Number or Rural Route Number, City or Town, State) _____					
48. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
49. SIGNATURE AND TITLE OF CERTIFIER <i>Hoon Gi Hong / Medical Resident</i>				50. LICENSE NUMBER _____		51. DATE SIGNED (Month, Day, Year) 8/13/91	
52. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>HODN Gi Hong St. Agnes Hospital</i>							
53. DATE FILED (Month, Day, Year) AUG 14 1991				54. REGISTRAR'S SIGNATURE <i>Julia K. ...</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

at 51220

1. FOR  
STATE  
REGISTRAR

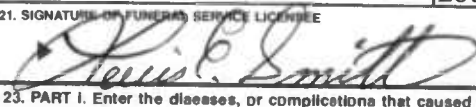
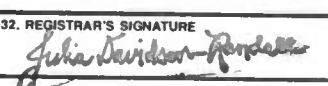
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21951

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last) <b>NORMA JULIA HULSEY</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 12 1991</b>		3. TIME OF DEATH <b>12:30A M</b>	
4. SOCIAL SECURITY NUMBER <b>218-07-3079</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV 26, 1918</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>CHERRYWOOD MANOR EXTENDED CARE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>REISTERSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>75 OAKLEE VILLAGE</b>				10f. ZIP CODE <b>21229</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH GRADE</b> College (1-4 or 5+) <b>CREDIT MANAGER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>RETAIL SALES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM ANDREW METCALF</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NORMA ELIZABETH BRUCE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOANNE KLOBY</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>634 LONGVIEW DRIVE, BALTIMORE, MD. 21228</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK MAUSOLEUM</b>		DATE <b>8/15</b>		20c. LOCATION — City or Town, State <b>BALTIMORE</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>HUBBARD FUNERAL HOME INC. 4107 WILKENS AVENUE, BALTIMORE, MD. 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Carcinoma of Lung</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Coronary Artery Disease</b> <b>Arteriosclerotic Cardiovascular Disease</b>							
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>GARY A MANKO</b>				29c. LICENSE NUMBER <b>025062</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-12-1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. GARY A. MANKO, 11 E. CHESTNUT HILL, REISTERSTOWN, MD. 21136 (SUITE 5)</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE 					

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) FORMAN, ISAIH				2. DATE OF DEATH MONTH 08 / DAY 10 / YEAR 91		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 217-12-7646		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) 03/31/18	
8. BIRTHPLACE (State or Foreign Country) SOUTH CAROLINA				9a. FACILITY NAME (If not institution, give street and number) 304 MT. HOLLY ST.		9b. CITY, TOWN OR LOCATION OF DEATH BALTO., CITY	
9c. COUNTY OF DEATH				10a. STATE MARYLAND		10b. COUNTY	
10c. CITY, TOWN OR LOCATION BALTIMORE CITY				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER 304 MT. HOLLY ST.	
10f. ZIP CODE 21229				10g. CITIZEN OF WHAT COUNTRY? U.S.A.		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: BLACK	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) HENRY FORMAN				18. MOTHER'S NAME (First, Middle, Maiden Surname) MARY UPSHUR			
19a. INFORMANT'S NAME (Type/Print) ISAIAH FORMAN JR.				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 304 MT. HOLLY ST. BALTO. MD. 21229			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) BALTIMORE NATIONAL CEM.		20c. LOCATION — City or Town, State BALTO., MD.	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Dortia Gibson				22. NAME AND ADDRESS OF FACILITY WM. C. MARCH FUNERAL HOME 4300 WABASH AVE.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. BRONCHOPNEUMONIA, LOWER LOBE, BILATERAL DUE TO (OR AS A CONSEQUENCE OF): b. ADENOCARCINOMA OF PROSTATE GLAND WITH METASTASIS DUE TO (OR AS A CONSEQUENCE OF): c. TO BONE DUE TO (OR AS A CONSEQUENCE OF): d. STATUS POST RADIATION THERAPY							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. PULMONARY FIBROSIS							24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined			
28a. DATE OF INJURY (Month, Day, Year)				28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.			
29b. SIGNATURE AND TITLE OF CERTIFIER Michael E. Pelczar, M.D.				29c. LICENSE NUMBER D09990		29d. DATE SIGNED (Month, Day, Year) 08/12/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Michael E. Pelczar MD St. Agnes Hospital, Baltimore MD							
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR STATE REGISTRAR		STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				REG. NO.	
1. DECEDENT'S NAME (First, Middle, Last)		2. DATE OF DEATH		3. TIME OF DEATH			
Frank JUNG		8 DAY 9 97		10:15 A.M.			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH	
217-30-5273		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		54 YRS.		9-29-36	
8. BIRTHPLACE (State or Foreign Country)		9a. FACILITY NAME (If not institution, give street and number)		9b. CITY, TOWN OR LOCATION OF DEATH		9c. COUNTY OF DEATH	
GEORGIA		UNIVERSITY OF MD		BALTIMORE			
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?	
MD				BALTIMORE CITY		1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER		10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
715 McCabe Avenue		21212		U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.	
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: BLACK	
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		Specify:			
15. DECEDENT'S EDUCATION		16a. DECEDENT'S USUAL OCCUPATION		16b. KIND OF BUSINESS/INDUSTRY			
(Specify only highest grade completed)		(Give kind of work done during most of working life. Do NOT use retired.)					
12TH		DISABLED					
17. FATHER'S NAME (First, Middle, Last)		18. MOTHER'S NAME (First, Middle, Maiden Surname)					
FRANK JUNG I		REAVES STROZIER					
19a. INFORMANT'S NAME (Type/Print)		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
YVONNA JUNG		715 MCCABE AVENUE/BALTIMORE, MD 21212					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, or other place)		DATE		20c. LOCATION — City or Town, State	
1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		CEDAR HILL CEMETERY				ANNE ARUNDEL CO, MD	
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE		22. NAME AND ADDRESS OF FACILITY					
Calvin L. Williams		WM.C.MARCH F.H./1101 E. NORTH AVE.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.		Approximate Interval Between Onset and Death					
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		3 days					
a. Respiratory failure due to pneumonia		4/91					
b. HIV (+)		May/June 91					
c. Non-Hodgkin's lymphoma							
d.							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		24a. WAS AN AUTOPSY PERFORMED?		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
Renal failure		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?		26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA					
27. MANNER OF DEATH		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation				M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
6 <input type="checkbox"/> Could not be determined							
29a. CERTIFIER (Check only one)		29b. SIGNATURE AND TITLE OF CERTIFIER		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		DR Michael Sommerhaus M.D.				8/9/91	
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)					
		DR MICHAEL SOMMERHAUS, 712 DUCKETS LN #104, ELURIDGE, MD 21227 USA					
31. DATE FILED (Month, Day, Year)		32. REGISTRAR'S SIGNATURE					
AUG 14 1991		John Davidson-Randall					

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MARY B. JAKUBOWSKI</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH M
4. SOCIAL SECURITY NUMBER <b>215-12-9120</b>	5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1-1-16</b>
8. FACILITY NAME (If not institution, give street and number) <b>FRANCIS SCOTT KEY MED CTR</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>BALT. CITY</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT				
10a. STATE <b>MD</b>	10b. COUNTY <b>BALTIMORE</b>	10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
10e. STREET AND NUMBER <b>7321 KIRTLEY RD.</b>		10f. ZIP CODE <b>21224</b>	10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:
14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>7 TH</b> College (1-4 or 5+) <b>HOUSEWIFE</b>		
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>WALTER PIASKOWSKI</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>JOSEPHINE LICARDO</b>		
19a. INFORMANT'S NAME (Type/Print) <b>JOHN JAKUBOWSKI</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>322 MARGARET AVE BALT, MD 21221</b>		
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>SAC HEART OF MARY CEM 8/17/91</b>		20c. LOCATION — City or Town, State <b>BALT, MD.</b>
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Colt Connelly</b>		22. NAME AND ADDRESS OF FACILITY <b>CONNELLY FUNERAL HOME OF DUNDALK 7110 SOLLERS PT. RD BALT, MD 21222</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Septic</b>  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>Rheumatoid Arthritis</b>  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.				Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.				24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input checked="" type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		
28a. DATE OF INJURY (Month, Day, Year) <b>8/13/91</b>		28b. TIME OF INJURY <b>6A</b> M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		
29b. SIGNATURE AND TITLE OF CERTIFIER <b>H. J. Davidson, H.D.</b>		29c. LICENSE NUMBER <b>D38048</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/14/91</b>
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Howard Gordon; 1636 Belair Rd, Balt 21235</b>				
31. DATE FILED (Month, Day, Year) <b>8/14/91</b>		32. REGISTRAR'S SIGNATURE <b>AUG 14 1991 Julia Davidson-Randall</b>		

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

91 51224

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, and 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21955

1. DECEDENT'S NAME (First, Middle, Last) <i>Felina Johnson</i>				2. DATE OF DEATH MONTH <i>8</i> - DAY <i>8</i> - YEAR <i>91</i>				3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER <i>213-30-2010</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>59</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>4-9-1932</i>		8. BIRTHPLACE (State or Foreign Country) <i>VIRGINIA</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>408 N. Denison St</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>				9c. COUNTY OF DEATH			
10a. STATE <i>Maryland</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>408 N. Denison St</i>				10f. ZIP CODE <i>21223</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or +) <i>N/A</i>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Homemaker</i>		16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <i>Joseph Booker</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Felina Fowlkes</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Mr. George Johnson</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>408 N. Denison St.</i>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Loudon Park</i>		DATE		20c. LOCATION — City or Town, State <i>Balto. Md.</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>				22. NAME AND ADDRESS OF FACILITY <i>Joseph L. Russ Funeral Home 2222 W. North Ave. Balt. Md. 21216</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>a. breast cancer, metastatic</i> DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death <i>yr</i>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation a <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Julia Gordon-Randall MD</i>				29c. LICENSE NUMBER <i>D15587</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/8/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)											
31. DATE FILED (Month, Day, Year) <i>AUG 14 1991</i>											

21 2122

91 21956

FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Susie Johnson</i>				2. DATE OF DEATH MONTH <i>8</i> DAY <i>9</i> YEAR <i>91</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>213 36 9343</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>90</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>12-14-00</i>	
8. BIRTHPLACE (State or Foreign Country) <i>MARYLAND</i>				9a. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>		9c. COUNTY OF DEATH	
9b. FACILITY NAME (If not institution, give street and number) <i>Liberty Med Center</i>				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1332 N. CAREY ST</i>	
10f. ZIP CODE <i>21217</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			
14. RACE — American Indian, Black, White, etc. Specify: <i>NEGRO</i>				15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>			
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOME MAINTENANCE</i>				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <i>SAM DAVIS</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>EMMA GROSS</i>			
19a. INFORMANT'S NAME (Type/Print) <i>GWENDOLYN LEE</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1332 N. CAREY ST BALTO MD 21217</i>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>ST THOMAS CEM 8-14-91</i>			
20c. LOCATION — City or Town, State <i>PANDALUSTOWN MD</i>				21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. Russ</i>			
22. NAME AND ADDRESS OF FACILITY <i>JOSEPH L. RUSS F.N. 2222 W. NORTH AVE BALTO MD 21216</i>				23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Hypertensive heart disease (conduction system)</i>  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  <i>Hypertension</i>  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>① Atrial fibrillation @ Congestive heart failure, ② Coronary artery disease</i>			
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO <i>N/A</i>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <i>Richard J. Gross</i>			
29c. LICENSE NUMBER <i>018758</i>				29d. DATE SIGNED (Month, Day, Year) <i>8/9/91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Richard J. Gross MD, Suite 101, 50 South Adams Ave., Cockeysville, MD 21030</i>				31. DATE FILED (Month, Day, Year) <i>AUG 14 1991</i>			
32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, 21, 22, 23, 24, 25, 26, 27, 28, 29, 30, 31, 32, 33, 34, 35, 36, 37, 38, 39, 40, 41, 42, 43, 44, 45, 46, 47, 48, 49, 50, 51, 52, 53, 54, 55, 56, 57, 58, 59, 60, 61, 62, 63, 64, 65, 66, 67, 68, 69, 70, 71, 72, 73, 74, 75, 76, 77, 78, 79, 80, 81, 82, 83, 84, 85, 86, 87, 88, 89, 90, 91, 92, 93, 94, 95, 96, 97, 98, 99, 100, 101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916, 917, 918, 919, 920, 921, 922, 923, 924, 925, 926, 927, 928, 929, 930, 931, 932, 933, 934, 935, 936, 937, 938, 939, 940, 941, 942, 943, 944, 945, 946, 947, 948, 949, 950, 951, 952, 953, 954, 955, 956, 957, 958, 959, 960, 961, 962, 963, 964, 965, 966, 967, 968, 969, 970, 971, 972, 973, 974, 975, 976, 977, 978, 979, 980, 981, 982, 983, 984, 985, 986, 987, 988, 989, 990, 991, 992, 993, 994, 995, 996, 997, 998, 999, 1000.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Evelyn Johnson</i>				2. DATE OF DEATH MONTH <i>8</i> - DAY <i>8</i> - YEAR <i>91</i>		3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER <i>215-12-0798</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>81</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>2-9-10</i>	
8. BIRTHPLACE (State or Foreign Country) <i>N.C.</i>				9a. FACILITY NAME (If not institution, give street and number) <i>1610 Pressbury St</i>		9b. CITY, TOWN OR LOCATION OF DEATH <i>Baltimore City</i>	
9c. COUNTY OF DEATH				10a. STATE <i>Maryland</i>		10b. COUNTY	
10c. CITY, TOWN OR LOCATION <i>Baltimore</i>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <i>1610 PRESBURY ST</i>	
10f. ZIP CODE <i>21217</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced	
12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>NEGRO</i>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>N/A</i> College (1-4 or 5+) <i>N/A</i>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>HOMEMAKER</i>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <i>DAVID WILLIAM FULLER</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>JULIA LYON</i>			
19a. INFORMANT'S NAME (Type/Print) <i>Rev. MORRIS D. JOHNSON</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1610 PRESBURY ST BALTO MD 21217</i>			
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify) <i>EMTOMBMENT</i>				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>WOODLAWN CEM 8/12/91</i>		20c. LOCATION — City or Town, State <i>BALTO CO MD</i>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Joseph L. RUDD</i>				22. NAME AND ADDRESS OF FACILITY <i>JOSEPH L. RUDD F.H. 2222 W. NORTH AVE BALTO MD 21216</i>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>MALIGNANCY OF THE HEART</i> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>ALZHEIMER'S DISEASE</i>							24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 8 <input type="checkbox"/> Nomicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Thomas S. Miller</i>				29c. LICENSE NUMBER <i>D30272</i>		29d. DATE SIGNED (Month, Day, Year) <i>8/9/91</i>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>THOMAS S. MILLER 700 WASH. NGTON BLVD. BALTO., MD</i>							
31. DATE FILED (Month, Day, Year) <i>AUG 14 1991</i>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i> <i>21230</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the funeral permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21958	
CERTIFICATE OF DEATH				REG. NO.					
1. DECEDENT'S NAME (First, Middle, Last) Vernon Douglas				2. DATE OF DEATH MONTH 8 DAY 7 YEAR 91		3. TIME OF DEATH M			
4. SOCIAL SECURITY NUMBER 216-18-0051		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	6. AGE (In yrs. last birthday) 67 YRS.	IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.	7. DATE OF BIRTH (Month, Day, Year) 12-4-23		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) 827 Mt. Holly St.				9b. CITY, TOWN OR LOCATION OF DEATH Balto.				9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT									
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Balto.		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER 827 Mt. Holly St.				10f. ZIP CODE 21229		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Chief Stewart		16b. KIND OF BUSINESS/INDUSTRY Merchant Seaman					
17. FATHER'S NAME (First, Middle, Last) Oscar Douglas				18. MOTHER'S NAME (First, Middle, Maiden Surname) Ruth Warner					
19a. INFORMANT'S NAME (Type/Print) Marjorie Douglas				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 827 Mt. Holly St. 21229					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) Garrison Forest V.A. 8/13/91		20c. LOCATION — City or Town, State OWINGS MILLS, MD					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE Hala March				22. NAME AND ADDRESS OF FACILITY March Funeral Home 4300 Wabash Ave.					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic malignancy 10 hepatocellular CA b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO								25b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)				27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year) 28b. TIME OF INJURY M 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO 28d. DESCRIBE HOW INJURY OCCURRED	
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER Julia Davidson-Randall				29c. LICENSE NUMBER 29d. DATE SIGNED (Month, Day, Year) 8/9/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) 3100 W. York Park Dr. 103									
31. DATE FILED (Month, Day, Year) AUG 14 1991				32. REGISTRAR'S SIGNATURE Julia Davidson-Randall					

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO BE COMPLETED BY FUNERAL DIRECTOR

1 FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO. 91 21959


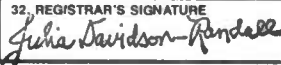
1. DECEDENT'S NAME (First, Middle, Last) <b>Ethel Tilghman JONES</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12 30 P M</b>					
4. SOCIAL SECURITY NUMBER <b>218-14-0411</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>92</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>3-6-1899</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTO., CITY</b>				9c. COUNTY OF DEATH			
10a. STATE <b>MARYLAND</b>				10b. COUNTY				10c. CITY, TOWN OR LOCATION <b>BALTO., CITY</b>			
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>5018 PEMBRIDGE AVE.</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>UNKNOWN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE TILGHMAN</b>							
19a. INFORMANT'S NAME (Type/Print) <b>DOROTHY SNOWDEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5018 PEMBRIDGE AVE BALTO., MD. 21215</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium or other place) <b>DRUID RIDGE CEM. 8-16</b>		20c. LOCATION — City or Town, State <b>PIKESVILLE, MD.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Portia Ebron</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. Metastatic Gastric Cancer</b> <b>Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST</b> b. <b>CHF</b> c. d. <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b> <b>DUE TO (OR AS A CONSEQUENCE OF):</b>								Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Choong Kim, MD. C Kim</b>						29c. LICENSE NUMBER <b>038485</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Liberty Medical Center, Baltimore, MD 21215</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

at 1925

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21960

1. DECEDENT'S NAME (First, Middle, Last) <b>CHARLES M. JACKSON</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:40 A M</b>			
4. SOCIAL SECURITY NUMBER <b>215-12-1062</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>9-10-1920</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Loch Raven Veterans Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>			9c. COUNTY OF DEATH <b>- - -</b>		
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>			10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		
10e. STREET AND NUMBER <b>409 Schwartz Ave.</b>				10f. ZIP CODE <b>21212</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Unknown</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Farm Worker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Farms</b>					
17. FATHER'S NAME (First, Middle, Last) <b>William Edward Jackson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Cornelia Davis</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Priscilla Jackson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>409 Schwartz Ave., Balto., Md. 21212</b>					
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory</b>		20c. LOCATION — City or Town, State <b>Balto., Md.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bradley-Ashton Funeral Home, INC. 2134 Willow Spring Rd., Dundalk, Md. 21222</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>Cardiopulmonary arrest</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. <b>Sepsis</b> DUE TO (OR AS A CONSEQUENCE OF): c. <b>pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF): d.								Approximate Interval Between Onset and Death  <b>1 wk</b>  <b>1 wk</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carol M. Klim M.D. SR 0383</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carol M. Klim MD Loch Raven VA medical Center</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE 							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been completed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 is marked, the medical examiner must be notified at once.

62-12-17

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91-21961

1. DECEDENT'S NAME (First, Middle, Last) <b>GEORGE KNOX</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>248-48-2039</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>09-11-32</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>606 E. BIDDLE STREET</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE, MD</b>		9c. COUNTY OF DEATH <b>S.C.</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, CITY</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>606 E. BIDDLE STREET</b>				10f. ZIP CODE <b>21202</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>10th</b> College (1-4 or 5+) <b>College</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DISABLED</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>JERRY GOODWIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LEOLA KNOX</b>			
19a. INFORMANT'S NAME (Type/Print) <b>VENUS KNOX</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>606 E. BIDDLE ST./BALTIMORE, MD. 21202</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematorium, or other place) <b>VOSHELL MEMORIAL GARDENS</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Wane</b>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARCINOMA OF THE LUNG - CELL TYPE UNKNOWN</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate interval between Onset and Death: <b>2 YEARS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE NOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Joseph A. Nasalotti</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>J.H.H. 1000 N. BROADWAY TOWER 110 BALD. MD 21205</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			





TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21962			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>MARTHA KREEK</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 12, 1991</b>		3. TIME OF DEATH <b>M</b>					
4. SOCIAL SECURITY NUMBER <b>213-30-5619</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>77</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>Sept 7, 1913</b>		8. BIRTHPLACE (State or Foreign Country) <b>Estonia</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>10 S. Ann Street</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH					
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>10 S. Ann Street</b>		10f. ZIP CODE <b>21231</b>		10g. CITIZEN OF WHAT COUNTRY? <b>Estonia</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>12 yr's</b>		16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Seamstress</b>		17. KIND OF BUSINESS/INDUSTRY <b>Clothes</b>							
17. FATHER'S NAME (First, Middle, Last) <b>Friedrich Konrad Marquart</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Miina Unknown</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Miss Piret Kreek</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1916 High Point Rd. Forest Hill, MD 21050</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith 8/17/91</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Paul L. Hartsock, Jr.</b>		22. NAME AND ADDRESS OF FACILITY <b>Baltimore, MD. 21214 Leonard J. Ruck, Inc. 5305 Harford Rd.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>Metastatic Adenocarcinoma of the Colon</b> IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST								Approximate interval Between Onset and Death <b>2 yr 3 mo</b>			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Glen Lesser M.D.</b>				29c. LICENSE NUMBER <b>D41620</b>				29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Glen Lesser, M.D. Johns Hopkins Hospital</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

50213 10

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 1-2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH MONTH DAY YEAR				3. TIME OF DEATH H M	
JOSEPH JOHN KAGAN				08 13 91				0925	
4. SOCIAL SECURITY NUMBER		5. SEX	6. AGE (in yrs. last birthday)	7. DATE OF BIRTH (Month, Day, Year)		8. BIRTHPLACE (State or Foreign Country)			
015-03-7012		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F	83 YRS.	3-25-08		MASSACHUSETTS			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH	
ST. AGNES HOSPITAL				BALTIMORE CITY					
RESIDENCE OF DECEDENT									
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS?			
MARYLAND		BALTIMORE		HALETHORPE		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY?			
1002 PLOVER COURT				21227		USA			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.			
1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		Specify: WHITE			
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5+)				SUPERVISOR		WESTINGHOUSE			
8th Grade									
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)					
JOHN KAGEN				LOUISE KAPINAS					
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)					
RICHARD J. KAGAN				1103 BROADVIEW BLVD, FERNDALE, MD. 21061					
20a. METHOD OF DISPOSITION		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place)		DATE		20c. LOCATION — City or Town, State			
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		MEADOWRIDGE CEMETERY		8-16		ELKRIDGE, MARYLAND			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY					
Dawn Z. Fisher				HOWARD H. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD. 21229					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death	
IMMEDIATE CAUSE (Final disease or condition resulting in death) →									
a. Massive Myocardial Infarction.									
DUE TO (OR AS A CONSEQUENCE OF):									
b. ASCVD.									
DUE TO (OR AS A CONSEQUENCE OF):									
c.									
DUE TO (OR AS A CONSEQUENCE OF):									
d.									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?	
CVA.								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
Pos. Sepsis.								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?	
								1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				26. PLACE OF DEATH (Check only one)					
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY		28c. INJURY AT WORK?	
1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide						M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29b. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)	
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								8-13-91	
29b. SIGNATURE AND TITLE OF CERTIFIER				29c. LICENSE NUMBER				29d. DATE SIGNED (Month, Day, Year)	
D. G. = Medical Resident.									
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
DNEY L. LUNIGA MD SAH - Balt MD.									
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE					
AUG 14 1991				John Fisher Registrar					

81 51223

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 6 of this form should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21964

1. DECEDENT'S NAME (First, Middle, Last) <b>Julius Knight</b>		2. DATE OF DEATH MONTH DAY YEAR <b>August 11, 1991</b>		3. TIME OF DEATH <b>11:11 A M</b>	
4. SOCIAL SECURITY NUMBER <b>242-18-8891</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>72</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>10-29-18</b>		8. BIRTHPLACE (State or Foreign Country) <b>NORTH CAROLINA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore CITY</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>1510 MOSHER ST.</b>		10f. ZIP CODE <b>21217</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE YEAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)	
16. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		17. FATHER'S NAME (First, Middle, Last) <b>JAMES H. KNIGHT</b>		18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MAMIE GRAY</b>	
19a. INFORMANT'S NAME (Type/Print) <b>FANNIE KNIGHT</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1510 MOSHER ST. BALTO., MD. 21217</b>		20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)	
20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VET. CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>		21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Gibson</i>	
22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>		23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>Malignant Arrhythmias</b> <b>R/O Myocardial Infarction</b> <b>Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>		Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Diabetes</b> <b>Multiple cerebral Vascular Accidents</b> <b>Dementia</b>		24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined	
28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>H. Farhat</i>		29c. LICENSE NUMBER <b>NA</b>	
29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>		30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Hassan Farhat, M.D. C/O Maryland General Hospital 827 Linden Avenue</b>		31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>	
32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>					

13335

91 21965

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SOL KLEIN</b> (SOL Z. KLEIN)				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>3:57A</b>	
4. SOCIAL SECURITY NUMBER <b>213-28-3842</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>83</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>NOV. 10, 1907</b>	
8a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				8b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		8c. COUNTY OF DEATH <b>MARYLAND</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2725 HANSON AVE.</b>				10f. ZIP CODE <b>21209</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PRESIDENT</b>		16b. KIND OF BUSINESS/INDUSTRY <b>KLEIN AUTO WORKS</b>			
17. FATHER'S NAME (First, Middle, Last) <b>TOBIAS KLEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRIEDA (UNKNOWN)</b>			
19a. INFORMANT'S NAME (Type/Print) <b>RABBI NORMAN KLEIN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6703 WESTERN RUN DR. BALTIMORE, MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BETH JACOB ANSHE VESHEAR</b>		20c. LOCATION — City or Town, State <b>8/12/91 ROSEDALE, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>		22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC.</b> <b>6010 REISTERSTOWN RD. BALTO., MD 21215</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Cardiac arrest</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>pulmonary embolism</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input type="checkbox"/> NO	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>A. Rahman, MD</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month/Day/Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Alfred Rahman, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21966					
CERTIFICATE OF DEATH				REG. NO.									
1. DECEDENT'S NAME (First, Middle, Last) <b>Glenn E. Lewis</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08/10/91</b>				3. TIME OF DEATH HOUR MIN <b>22:58</b>					
4. SOCIAL SECURITY NUMBER <b>577 78 3890</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>34</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/22/57</b>		8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>Washington Adventist Hosp.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Takoma Park, Maryland</b>				9c. COUNTY OF DEATH <b>Montgomery</b>					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Montgomery</b>		10c. CITY, TOWN OR LOCATION <b>Takoma Park, 8342 Eastridge Ave #6</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>8342 Eastridge Avenue #6</b>				10f. ZIP CODE <b>20912</b>				10g. CITIZEN OF WHAT COUNTRY? <b>United states</b>					
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12) 12th</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Banquet Manager</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Private</b>					
17. FATHER'S NAME (First, Middle, Last) <b>Perry A. Lewis, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Margaret Kinard</b>									
19a. INFORMANT'S NAME (Type/Print) <b>Margaret Lewis</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6733 New Hampshire Avenue Takoma Park</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Fort Lincoln Cemetery 8/15/91 Brentwood, Md.</b>		DATE <b>8/15/91</b>		20c. LOCATION — City or Town, State <b>Brentwood, Md.</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>John T. Stewart II</i>				22. NAME AND ADDRESS OF FACILITY <b>Stewart Funeral Home 4001 Benning Road, NE.</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>acquired immune Deficiency Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>Syndrome</b> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death													
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)									
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								29b. SIGNATURE AND TITLE OF CERTIFIER <i>John T. Stewart II</i>		29c. LICENSE NUMBER <b>D08546</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-11-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>John T. Stewart II 8218 Wisconsin Ave Bethesda Md</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>John T. Stewart II</i>									

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 2 should be filled within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

1 - FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				01 21967			
1. DECEDENT'S NAME (First, Middle, Last)				2. DATE OF DEATH				3. TIME OF DEATH			
Robert W. Long Jr.				8 10 91				742 A.M.			
4. SOCIAL SECURITY NUMBER		5. SEX		6. AGE (In yrs. last birthday)		7. DATE OF BIRTH		8. BIRTHPLACE (State or Foreign Country)			
075-42-1916		1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		40 YRS.		12-29-50		NEW YORK			
9a. FACILITY NAME (If not institution, give street and number)				9b. CITY, TOWN OR LOCATION OF DEATH				9c. COUNTY OF DEATH			
Loch Raven VA Medical Center				BALTIMORE							
10a. STATE		10b. COUNTY		10c. CITY, TOWN OR LOCATION				10d. INSIDE CITY LIMITS?			
MD				Baltimore				1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER				10f. ZIP CODE				10g. CITIZEN OF WHAT COUNTRY?			
5202 NORWOOD AVE.				21207				U.S.A.			
11. MARITAL STATUS		12. WAS DECEDENT EVER IN U.S. ARMED FORCES?		13. WAS DECEDENT OF HISPANIC ORIGIN?		14. RACE — American Indian, Black, White, etc.					
1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		Specify: BLACK					
3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		IF YES, GIVE WAR OR DATES		If yes, specify Cuban, Mexican, Puerto Rican, etc.)							
15. DECEDENT'S EDUCATION (Specify only highest grade completed)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY			
Elementary/Secondary (0-12) College (1-4 or 5+)											
17. FATHER'S NAME (First, Middle, Last)				18. MOTHER'S NAME (First, Middle, Maiden Surname)							
ROBERT LONG SR.				LENA B. JACKSON							
19a. INFORMANT'S NAME (Type/Print)				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code)							
LENA BERNICE LONG				5202 NORWOOD AVE., BALTO., MD. 21207							
20a. METHOD OF DISPOSITION		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place)		20c. LOCATION — City or Town, State							
1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State		GARRISON FOREST VET. CEM.		OWINGS MILLS, MD.							
4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)											
21. SIGNATURE OF FUNERAL SERVICE LICENSEE				22. NAME AND ADDRESS OF FACILITY							
L. Fortin Chron				WM. C. MARCH FUNERAL HOME							
4300 WABASH AVE.											
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.								Approximate Interval Between Onset and Death			
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. cardiac arrest											
DUE TO (OR AS A CONSEQUENCE OF):											
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. metabolic abnormality								2 days			
DUE TO (OR AS A CONSEQUENCE OF):											
c. shock								2 days			
DUE TO (OR AS A CONSEQUENCE OF):											
d. upper GI bleed								3 days			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED?			
ethanol abuse								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH?			
								1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER?				28. PLACE OF DEATH (Check only one)							
1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH				28a. DATE OF INJURY		28b. TIME OF INJURY		28c. INJURY AT WORK?		28d. DESCRIBE HOW INJURY OCCURRED	
1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined				(Month, Day, Year)		M		1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
				28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28t. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one)				29c. LICENSE NUMBER							
1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				MR0538							
2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29d. DATE SIGNED (Month, Day, Year)							
				8/16/91							
29b. SIGNATURE AND TITLE OF CERTIFIER				30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)							
Elizabeth Capacio MD				EW Capacio LRVAMC Baltimore, MD							
31. DATE FILED (Month, Day, Year)				32. REGISTRAR'S SIGNATURE							
AUG 14 1991				Julia Davidson-Randall							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) Mary L. Mazziotte				2. DATE OF DEATH August 11, 1991				3. TIME OF DEATH M	
4. SOCIAL SECURITY NUMBER 213-74-9631		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 94 YRS.		7. DATE OF BIRTH Sept. 27, 1896		8. BIRTHPLACE (State or Foreign Country) Md.	
9a. FACILITY NAME (If not institution, give street and number) 533 Maple Ridge Lane				9b. CITY, TOWN OR LOCATION OF DEATH Odenton				9c. COUNTY OF DEATH Anne Arundel	
10a. STATE Md.		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 2912 Gibbons Avenue				10f. ZIP CODE 21214		10g. CITIZEN OF WHAT COUNTRY? USA			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES X		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. White			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 5 College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Homemaker		16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) Lawrence Popoli				18. MOTHER'S NAME (First, Middle, Maiden Surname) Amelia -					
19a. INFORMANT'S NAME (Type/Print) Margaret M. Clayton				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 533 Maple Ridge Lane Odenton, Md. 21113					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or place of disposition) Most Holy Redeemer Aug. 14, 1991		DATE		20c. LOCATION — City or Town, State Baltimore, Md.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE James Gladden				22. NAME AND ADDRESS OF FACILITY Leonard J. Ruck Inc. 5305 Harford Road 21214					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → CONGESTIVE HEART FAILURE a. DUE TO (OR AS A CONSEQUENCE OF): AORTIC STENOSIS b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO								24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER Louis K. Essandoh, MD		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)									
31. DATE FILED (Month, Day, Year) AUG 14 1991		32. REGISTRAR'S SIGNATURE Julia Davidson-Rodarte							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Frances Mitchell</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>19:17 PM</b>		
4. SOCIAL SECURITY NUMBER <b>189 24 2571</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>62</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>6/5/29</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>ST Joseph Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>		
RESIDENCE OF DECEDENT				10c. CITY, TOWN OR LOCATION		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO		
10a. STATE <b>MARYLAND</b>		10b. COUNTY		<b>BALTIMORE CITY</b>				
10e. STREET AND NUMBER <b>4563 THE STRAND</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 8+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <b>FELIX VAUGHN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FRANCES REMBERT</b>				
19a. INFORMANT'S NAME (Type/Print) <b>ROBERT MITCHELL</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4563 THE STRAND BALTIMORE, MD. 21215</b>				
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WOODLAWN CEM.</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD.</b>		
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Gladys Wane</b>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ENDSTAGE RENAL FAILURE</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <b>DIABETIC NEPHROPATHY</b> c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b>							Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO				
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)				
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)								
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Francis T. Khoo</b>				29c. LICENSE NUMBER <b>D 30263</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-11-91</b>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>FRANCIS T. KHOO, ST. JOSEPH HOSPITAL</b>								
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>				

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>JOHN D. MATTHEWS JR.</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:22 P M</b>	
4. SOCIAL SECURITY NUMBER <b>214-52-1778</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>2-27-49</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>905 WILMINGTON AVENUE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEDENT							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <b>1</b> <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>905 WILMINGTON AVENUE</b>				10f. ZIP CODE <b>21223</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <b>1</b> <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <b>3</b> <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th gr.</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>RADAR COORDINATOR</b>		16b. KIND OF BUSINESS/INDUSTRY <b>WESTINGHOUSE</b>			
17. FATHER'S NAME (First, Middle, Last) <b>JOHN D. MATTHEWS, SR.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>AMELIA M. KUICK</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JOHN D., SR. &amp; Amelia MATTHEWS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>34 WALNUT LANE, SELBYVILLE, DELAWARE 19975</b>			
20a. METHOD OF DISPOSITION <b>1</b> <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <b>4</b> <input type="checkbox"/> Donation <b>5</b> <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>LOUDON PARK CEMETERY</b>		DATE <b>8-14</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Christopher H. Miles</i>				22. NAME AND ADDRESS OF FACILITY <b>HOWARD H. HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE, BALTIMORE, MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. <b>DIABETES MELLITUS, BLIND</b>							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>DIABETES MELLITUS, BLIND</b>							24a. WAS AN AUTOPSY PERFORMED? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <b>1</b> <input checked="" type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <b>1</b> <input type="checkbox"/> Inpatient <b>2</b> <input type="checkbox"/> ER/Outpatient <b>3</b> <input type="checkbox"/> DOA OTHER: <b>4</b> <input type="checkbox"/> Nursing Home <b>5</b> <input checked="" type="checkbox"/> Residence <b>6</b> <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <b>1</b> <input checked="" type="checkbox"/> Natural <b>5</b> <input type="checkbox"/> Pending Investigation <b>2</b> <input type="checkbox"/> Accident <b>3</b> <input type="checkbox"/> Suicide <b>6</b> <input type="checkbox"/> Could not be determined <b>4</b> <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <b>1</b> <input type="checkbox"/> YES <b>2</b> <input type="checkbox"/> NO	
		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <b>2</b> <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G. Wright MD</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G. WRIGHT MD DCME 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>J. Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

07912 10

91 21971

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) Willie Roy McCoy		2. DATE OF DEATH August 10, 1991		3. TIME OF DEATH 11:41am	
4. SOCIAL SECURITY NUMBER 249 47 5803		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) 60 YRS.	
7. DATE OF BIRTH 7-22-31		8. BIRTHPLACE (State or Foreign Country) South Carolina			
9a. FACILITY NAME (If not institution, give street and number) Maryland General Hospital		9b. CITY, TOWN OR LOCATION OF DEATH Baltimore City		9c. COUNTY OF DEATH	
10a. STATE Maryland		10b. COUNTY		10c. CITY, TOWN OR LOCATION Baltimore	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER 2905 Mt Holly St		10f. ZIP CODE 21205	
10g. CITIZEN OF WHAT COUNTRY? U.S.A		11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: Black		15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) N/A College (13-16 or 17+) N/A	
16. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) DISABILITY		17. KIND OF BUSINESS/INDUSTRY		18. DECEASED'S FATHER'S NAME (First, Middle, Last) Willie McCoy	
19. DECEASED'S MOTHER'S NAME (First, Middle, Last) Daisey Baskin		20. INFORMANT'S NAME (Type/Print) Katie Goodwin		21. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 4349 Eldon Rd Baltimore MD 21229	
22. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		23. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) Pleasant Grove Cem		24. LOCATION — City or Town, State Chesapeake S.C.	
25. SIGNATURE OF FUNERAL SERVICE LICENSEE Joseph L. Ruas		26. NAME AND ADDRESS OF FACILITY Joseph L. Ruas F.H. 2222 W. North Ave Baltimore, MD 21214		27. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. (restricted no head) Possible cerebrovascular accident with seizures IMMEDIATE CAUSE (Final disease or condition resulting in death) → Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. DUE TO (OR AS A CONSEQUENCE OF): Moderate coronary atherosclerotic disease with remote Myocardial infarction. b. DUE TO (OR AS A CONSEQUENCE OF): Marked edema and congestion of the lungs. c. DUE TO (OR AS A CONSEQUENCE OF): Acute/chronic pancreatitis d.	
28. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.		29a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		29b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
30. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		31. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		32. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined	
33. DATE OF INJURY (Month, Day, Year) 28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		34. TIME OF INJURY 28b. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		35. DESCRIBE HOW INJURY OCCURED 28c. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
36. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		37. SIGNATURE AND TITLE OF CERTIFIER Pete Pham		38. LICENSE NUMBER n/a	
39. DATE SIGNED (Month, Day, Year) 8/10/91		40. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) PETER S PHAM M.D. c/o Maryland General Hospital		41. DATE FILED (Month, Day, Year) AUG 14 1991	
42. REGISTRAR'S SIGNATURE John Davidson-Randall					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1-4, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ROBERT L. McFADDEN</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>09</b> YEAR <b>91</b>		3. TIME OF DEATH <b>12:17 A M</b>				
4. SOCIAL SECURITY NUMBER <b>217-52-9913</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>42</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8-9-49</b>		8. BIRTHPLACE (State or Foreign Country) <b>SOUTH CAROLINA</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>			9c. COUNTY OF DEATH			
10a. STATE <b>MARYLAND</b>				10b. COUNTY			10c. CITY, TOWN OR LOCATION <b>BALTO., CITY</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>4940 DENMORE AVE.</b>				10f. ZIP CODE <b>21215</b>			10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5 +)				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			15b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT MC FADDEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>SARA GREGG</b>						
19a. INFORMANT'S NAME (Type/Print) <b>RODNEY MC FADDEN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4435 PALL MALL ROAD BALTO., MD. 21215</b>						
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEM. PARK</b>			DATE <b>8-15</b>		20c. LOCATION — City or Town, State <b>RANDALLSTOWN, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Elton</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH FUNERAL HOME</b> <b>4300 WABASH AVE.</b>						
23. PART I. Enter the disease, or complication that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>MULTIPLE GUNSHOT WOUNDS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.  PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.  24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO  25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO  26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)  27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input checked="" type="checkbox"/> Homicide  28a. DATE OF INJURY (Month, Day, Year) <b>08/08/91</b>  28b. TIME OF INJURY <b>9:15P M</b>  28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO  28d. DESCRIBE HOW INJURY OCCURRED <b>Subject was shot</b>  28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>HOME</b>  28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>4940 DENMORE AVENUE</b>  29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.  29b. SIGNATURE AND TITLE OF CERTIFIER <i>Donald G Wright MD</i>  29c. LICENSE NUMBER <b>O.C.M.E.</b>  29d. DATE SIGNED (Month, Day, Year) <b>08/09/91</b>  30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DONALD G WRIGHT MD DCME 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>  31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>  32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>										

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 5 may be retained by the attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) MARY MAIZEL				2. DATE OF DEATH MONTH DAY YEAR August 9, 1991		3. TIME OF DEATH 12:15 A M	
4. SOCIAL SECURITY NUMBER 579 40 1468		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 73 YRS.		7. DATE OF BIRTH (Month, Day, Year) Oct. 14, 1917	
9a. FACILITY NAME (If not institution, give street and number) 10700 NEW HAMPSHIRE AVENUE				9b. CITY, TOWN OR LOCATION OF DEATH Silver Spring		9c. COUNTY OF DEATH Montgomery	
10a. STATE Maryland		10b. COUNTY Montgomery		10c. CITY, TOWN OR LOCATION Silver Spring		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER 10700 New Hampshire Avenue				10f. ZIP CODE 20903		10g. CITIZEN OF WHAT COUNTRY? United States	
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: White	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 years		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) Housewife		16b. KIND OF BUSINESS/INDUSTRY Own Home			
17. FATHER'S NAME (First, Middle, Last) Walter Plotkin				18. MOTHER'S NAME (First, Middle, Maiden Surname) Sarah Kurland			
19a. INFORMANT'S NAME (Type/Print) David Maizel				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) 10700 New Hampshire Avenue, Silver Spring, Maryland 20903			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) King David Memorial Garden		20c. LOCATION — City or Town, State Falls Church, Va.			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Edward C. Stettinmeyer</i>				22. NAME AND ADDRESS OF FACILITY STEIN HEBREW MEMORIAL FUNERAL HOME 232 CARROLL STREET, N.W., WASHINGTON, D.C.			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <i>Congestive Heart Failure</i> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. <i>Olivo Porton carabolan degeneration</i> DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. Approximate Interval Between Onset and Death 1 week YEARS							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.   							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input checked="" type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.		29b. SIGNATURE AND TITLE OF CERTIFIER <i>Alan R. Weinstock</i>		29c. LICENSE NUMBER 07748 MS		29d. DATE SIGNED (Month, Day, Year) 8/14/91	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) Dr. Alan R. Weinstock, M. D., 10313 Georgia Avenue, Silver Spring, Maryland 20902							
31. DATE FILED (Month, Day, Year) AUG 14 1991		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 13146, BALTIMORE, MARYLAND 21203-3146

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene.

IMPORTANT: If item 28 is marked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.





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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>John Nicholas Matricciani</b>		2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0345A M</b>	
4. SOCIAL SECURITY NUMBER <b>217-14-6885</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>74</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>7/2/17</b>		8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Stella Maris Hospice</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Towson</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>2801 Glavin Way Apt. F</b>		10f. ZIP CODE <b>21234</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW 2 1941-1943</b>	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b>College</b>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Longshoreman</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Shipping</b>		17. FATHER'S NAME (First, Middle, Last) <b>Massimo Matricciani</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Gulia Teresa Giovenga</b>		19a. INFORMANT'S NAME (Type/Print) <b>Amelia A. Matricciani</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2801 Glavin Way Apt. F Baltimore, MD 21234</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery or other place) <b>Most Holy Redeemer Cemetery 08/16/91</b>		20c. LOCATION — City or Town, State <b>Baltimore, MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>John J. Dippel</b>		22. NAME AND ADDRESS OF FACILITY <b>Dippel Funeral Home, Inc. 7110 Belair Road Baltimore, MD 21206</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Prostate Cancer</b> DUE TO (OR AS A CONSEQUENCE OF): Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.					Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.					24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
					24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>Hospice</b>			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		29a. CERTIFIER 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Carla S. Alexander</b>		29c. LICENSE NUMBER <b>D 27087</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Carla S. Alexander, M.D.—Stella Maris Hospice-Dulaney Valley Rd.—Towson 21204</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>John Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21975

1. DECEDENT'S NAME (First, Middle, Last) <b>Menn, Carl</b>		2. DATE OF DEATH MONTH <b>8</b> / DAY <b>6</b> / YEAR <b>1991</b>		3. TIME OF DEATH <b>12:23 A.M.</b>	
4. SOCIAL SECURITY NUMBER <b>101-10-51</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>69</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>3/10/1922</b>		8. BIRTHPLACE (State or Foreign Country) <b>Germany</b>		9. COUNTY OF DEATH <b>Balt.</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>U. of MD Hospital</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore MD</b>		9c. COUNTY OF DEATH <b>Balt.</b>	
RESIDENCE OF DECEDENT					
10a. STATE <b>Maryland</b>		10b. COUNTY <b>Baltimore Co.</b>		10c. CITY, TOWN OR LOCATION <b>Relay</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>5121 South Rolling Road</b>		10f. ZIP CODE <b>21227</b>	
10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>		11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>		15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>	
16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Upholsterer</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Self-Employed</b>		17. FATHER'S NAME (First, Middle, Last) <b>Paul Wilhelm Menn</b>	
18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Louise Fischbach</b>		19a. INFORMANT'S NAME (Type/Print) <b>Irma M. Kuhn</b>		19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8456 Old Frederick Road, Ellicott City, MD 21043</b>	
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Good Shepherd Cem. 8/9</b>		20c. LOCATION — City or Town, State <b>Ellicott City, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i> <b>M00535</b>		22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home Ellicott City, Maryland 21043</b>		23. PART I. Enter the diseases or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Glioblastoma Multiforme</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. SEQUENTIALLY list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b>	
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>8/6/91</b>	
28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.	
29b. SIGNATURE AND TITLE OF CERTIFIER <i>John Portelli M.D.</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/6/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>22 South Greene St., Balt MD</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Portelli</i>			

at 1912

1912-1913

1912-1913

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRAR

STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

91 21976  
REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <i>ANITA H. NORTON</i>				2. DATE OF DEATH MONTH <i>06</i> DAY <i>30</i> YEAR <i>91</i>		3. TIME OF DEATH <i>2:50 P M</i>		
4. SOCIAL SECURITY NUMBER <i>217-18-0173</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F	6. AGE (In yrs. last birthday) <i>72 YRS.</i>		7. DATE OF BIRTH (Month, Day, Year) <i>05-09-19</i>		8. BIRTHPLACE (State or Foreign Country) <i>MD</i>	
9a. FACILITY NAME (If not institution, give street and number) <i>BON SECOURS Hospital</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>		9c. COUNTY OF DEATH		
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTO</i>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		
10e. STREET AND NUMBER <i>5220 York Road</i>				10f. ZIP CODE <i>21212</i>		10g. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <i>Black</i>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY		
17. FATHER'S NAME (First, Middle, Last) <i>Frank Harcum</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Lucy</i>				
19a. INFORMANT'S NAME (Type/Print) <i>Calvin Nephlin</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1441 35th St S.E. Wash. DC 20020</i>				
20a. METHOD OF DISPOSITION 1 <input type="checkbox"/> Burial 2 <input checked="" type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Metro Crematory</i>		20c. LOCATION — City or Town, State <i>Catonsville, Md</i>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hola March</i>				22. NAME AND ADDRESS OF FACILITY <i>March F.H. West 4300 Wabash Ave</i>				
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>ARTERIOSCLEROTIC heart DISEASE</i> Due to (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <i>SEPSIS - INFECTED A-V. GRAFT</i> Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF): Due to (OR AS A CONSEQUENCE OF):						Approximate Interval Between Onset and Death		
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>CHRONIC RENAL FAILURE</i> <i>END STAGE RENAL DISEASE</i>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO						26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 6 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 6 <input type="checkbox"/> Could not be determined 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		
		28d. DESCRIBE HOW INJURY OCCURRED		28e. LOCATION (Street and Number or Rural Route Number, City or Town, State)				
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.								
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Curtis Edwards MD</i>				29c. LICENSE NUMBER <i>D-21240</i>		29d. DATE SIGNED (Month, Day, Year) <i>July 91</i>		
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>CURTIS EDWARDS BON SECOURS Hosp - 21223</i>								
31. DATE FILED (Month, Day, Year) <i>AUG 14 1991</i>				32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Randall</i>				

ST. 11

91 21977

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>FRANCES T. OATES</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>215-28-6173</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>82</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-29-1908</b>	
8. BIRTHPLACE (State or Foreign Country) <b>South Car.</b>				9a. FACILITY NAME (If not institution, give street and number) <b>6401 Loch Raven Blvd. Apt. 526</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH				10a. STATE <b>Maryland</b>			
10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>6401 Loch Raven Blvd.</b>				10f. ZIP CODE <b>21239</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input checked="" type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>6th grade</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Housewife</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Homemaking</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Nellie Russell</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Helene Pugh</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7111 Willowdale Avenue Balto., Md. 21206</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Gardens of Faith Cemetery</b>		20c. LOCATION — City or Town, State <b>Baltimore, Maryland</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Lassahn Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>Lassahn Funeral Home 7401 Belair Rd. Balto., Md. 21236</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MI</b>  Sequitely ill conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): <b>Hypertensive heart disease</b> c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death <b>X Immed</b>	
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>12 Rheumatoid Arthritis</b>						24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Dr. Stuart Bell</b>				29c. LICENSE NUMBER <b>D22789</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. Stuart Bell 3501 St. Paul St. Balto., Md. (889-8388)</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR FUNERAL HOME: The law requires that the death certificate be executed within 48 hours after death. Page 6 may be retained by the hospital or attending physician. The certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death in the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

10 21015

10 21015



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21978

1. DECEDENT'S NAME (First, Middle, Last) <b>Dominic S POLIGARDO</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 10, 1991</b>		3. TIME OF DEATH <b>11:58 p M</b>				
4. SOCIAL SECURITY NUMBER <b>217-03-6221</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>76</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-18-14</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>		
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>			9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Rosedale</b>			10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7926 Underhill Rd.</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>				
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WW II</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Elementary/Secondary (0-12)</b> <b>10</b>		15b. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Chauffeur</b>		15c. KIND OF BUSINESS/INDUSTRY <b>Teamsters</b>						
17. FATHER'S NAME (First, Middle, Last) <b>Salvadore Poligardo</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Salvadora Gagliona</b>						
19a. INFORMANT'S NAME (Type/Print) <b>Victoria Poligardo</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>7926 Underhill Rd. Baltimore, MD 21237</b>						
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>metro crematory</b>			20c. LOCATION — City or Town, State <b>Catonsville, MD</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Denise S. Kelly</i>				22. NAME AND ADDRESS OF FACILITY <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave.</b>						
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. Congestive Heart Failure</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. Renal Insufficiency</b> DUE TO (OR AS A CONSEQUENCE OF): <b>c.</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d.</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Cerebrovascular Accident</b> <b>Dementia</b>							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)								
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE NOW INJURY OCCURRED		
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)						
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.										
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Ramzi Nassar MD</i>				29c. LICENSE NUMBER <b>N/A</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/11/91</b>				
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Ramzi Nassar MD. 9000 Franklin Square Drive 21237</b>										
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Swickard</i>						

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Richard J. Purdie, Jr.</b>				2. DATE OF DEATH MONTH DAY YEAR <b>08 12 1991</b>		3. TIME OF DEATH <b>4:45 A M</b>	
4. SOCIAL SECURITY NUMBER <b>214-64-7530</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. MONTHS DAYS HOURS MIN. <b>04-17-54</b>		7. DATE OF BIRTH (Month, Day, Year) <b>04-17-54</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>Shock Trauma Center</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>	
9c. COUNTY OF DEATH <b>none</b>				10a. STATE <b>Maryland</b>		10b. COUNTY <b>none</b>	
10c. CITY, TOWN OR LOCATION <b>Baltimore City</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		10e. STREET AND NUMBER <b>4419 Pall Mall Road</b>	
10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>United States</b>		11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES	
13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>NEGROID</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12th grade</b> College (1-4 or 5+) <b>none</b>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Unemployed Printer</b>		18b. KIND OF BUSINESS/INDUSTRY <b>Printing</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Richard J. Purdie, Sr.</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mary Venable</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Mary Purdie</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>4419 Pall Mall Road, Balto, Md. 21215</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Mt. Zion August 14, 1991/Balto, Maryland</b>		20c. LOCATION — City or Town, State		20d. DATE	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin B. Scruggs Jr.</i>				22. NAME AND ADDRESS OF FACILITY <b>Calvin B. Scruggs Funeral Home 1412 E. Preston St. Balto, Md. 21213</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>GUNSHOT WOUNDS TO LEFT BUTTOCK &amp; RIGHT ARM WITH COMPLICATIONS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>WITH COMPLICATIONS</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST a. <b>ACQUIRED IMMUNE DEFICIENCY SYNDROME</b> b. c. d. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						Approximate Interval Between Onset and Death	
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input checked="" type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year) <b>05 10 1991</b>		28b. TIME OF INJURY <b>10:20 P</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>Subject shot</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>On street</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>600 blk. N. Hilton St.</b>			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Mark F. Golle, Jr.</i>				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08 13 1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO F. GOLLE, JR., MD 111 Penn Street, Baltimore Maryland 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Johanna Davidson-Rendell</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Georgia Anne Peltzer</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>1991</b>		3. TIME OF DEATH <b>1:30 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>219-78-0227</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>28</b> YRS.		7. DATE OF BIRTH Month, Day, Year <b>12-13-62</b>	
8. BIRTHPLACE (State or Foreign Country) <b>Maryland</b>				9a. FACILITY NAME (If not institution, give street and number) <b>HIGHWAY #695 150' NORTH OF HIGHWAY 151</b>		9b. CITY, TOWN OR LOCATION OF DEATH <b>DUNDALK</b>	
9c. COUNTY OF DEATH <b>BALTIMORE</b>				10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>	
10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		10e. STREET AND NUMBER <b>8023 Midhaven Rd.</b>	
10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>Unknown</b>		15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		15b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>			
17. FATHER'S NAME (First, Middle, Last) <b>George R. Ruth</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Annie Eward</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dudley M. Peltzer</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>8023 Midhaven Rd. Dundalk, Md. 21222</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 8-13-91 Balto. Md.</b>		DATE		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>Bradley-Ashton Funeral Home, Inc. 2134 Willow Spring Rd., Dundalk, Md. 21222</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Multiple injuries</b> DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input checked="" type="checkbox"/> Other (Specify) <b>PUBLIC HIGHWAY</b>			
27. MANNER OF DEATH <input type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year) <b>08/10/1991</b>		28b. TIME OF INJURY <b>12:40 a.m.</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED <b>PEDESTRIAN STRUCK BY AUTO</b>		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b>PUBLIC ROADWAY</b>		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b>HIGHWAYS #ed 695 &amp; 151 DUNDALK, MARYLAND</b>			
29a. CERTIFIER <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER 				29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/10/1991</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>A-M-D... 111 PENN STREET BALTIMORE, MARYLAND 21201</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE 			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH81 21981  
REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MATTIE RUCKER</b>				2. DATE OF DEATH MONTH DAY YEAR <b>Aug 12 1991</b>		3. TIME OF DEATH <b>6:50 PM</b>					
4. SOCIAL SECURITY NUMBER <b>188-16-5785</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7/29/1895</b>		8. BIRTHPLACE (State or Foreign Country) <b>HEKTFORD CO. NC.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSP OF BALTIMORE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>			
10a. STATE <b>Maryland</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2525 W. Belyverdere Avenue</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)				16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>John Vinson</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Sarah Vinson</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Deborah Brunson</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>603 N. Chapel Gate Road Balto, Md. 21229</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Garden of Eternal Hope</b>		20c. LOCATION — City or Town, State <b>Carroll Cty, Md. 21215</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>Leroy O. Dyett &amp; Son Funeral Home 4600 Liberty Heights Avenue 21207</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pneumonia</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.						Approximate Interval Between Onset and Death					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Dementia, CVA, hyperkalemia</b>						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.						29b. SIGNATURE AND TITLE OF CERTIFIER <i>Madhu Jain</i>		29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MADHU JAIN SINAI HOSPITAL, BALTIMORE MD</b>						31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

THE UNIVERSITY OF CHICAGO

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Jesse Jessie Richie Sr.</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>10:15 P M</b>	
4. SOCIAL SECURITY NUMBER <b>116-09-8667</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>75</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>8 9 16</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Liberty Med.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Balto.</b>		9c. COUNTY OF DEATH <b>U.S.A.</b>	
10a. STATE <b>md.</b>				10b. COUNTY <b>Balto</b>		10c. CITY, TOWN OR LOCATION <b>Balto</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>3707 Egerton Rd.</b>			
10f. ZIP CODE <b>21215</b>				10g. CITIZEN OF WHAT COUNTRY?			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Army L.T.C.</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>Jesse S. Richie</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Daisy Buckner</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Yosalyn Richie</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3707 Egerton Rd. 21215</b>			
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other) <b>Garrett Forest 81691 Owings Mills Md</b>		20c. LOCATION — City or Town, State	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Dale March</b>				22. NAME AND ADDRESS OF FACILITY <b>March General Home 4300</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Cardio Pulmonary arrest</b>							
DUE TO (OR AS A CONSEQUENCE OF): <b>b. Atrial Myocardial Infarction</b>							
Sequitely flat conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
DUE TO (OR AS A CONSEQUENCE OF):							
DUE TO (OR AS A CONSEQUENCE OF):							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				25. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> Outpatient <input type="checkbox"/> DCA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Raymond R. M.D.</b>				29c. LICENSE NUMBER <b>D15853</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.10.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>RAYA DURG GOVINDA RAO M.D.</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0070

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>MABEL HELOISE SCOTT</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>5</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2230</b> M	
4. SOCIAL SECURITY NUMBER <b>219-16-5063</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>80</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>4/22/11 Phila., PA.</b>	
8. FACILITY NAME (If not institution, give street and number) <b>BALTO. COUNTY GENERAL</b>				9a. CITY, TOWN OR LOCATION OF DEATH <b>BALTO. County</b>		9b. COUNTY OF DEATH <b>BALTO. County</b>	
10a. STATE <b>MARYLAND</b>		10b. COUNTY <b>BALTO.</b>		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>402 Gaither Ave.</b>		10f. ZIP CODE <b>21228</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>COOK-RETIRED</b>		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>ROBERT SCOTT</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Mable Kelly</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Thelma ENNAIS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State) <b>402 Gaither Ave. CATONSVILLE 21228</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory, etc.) <b>ME CANARY</b>		20c. DATE <b>8/10</b>		20d. LOCATION — City or Town, State <b>BALTO. MD.</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Blow Adams Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>Marshall W. Jones, Jr Funeral Home PA 4101 Edmondson Ave. Balto. MD 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d. DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Hepatic Failure</b> <b>Metastatic CARCINOMA</b>							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO					
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Could not be determined <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Barbara Sacha M.D.</b>				29c. LICENSE NUMBER <b>D35609</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/5/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Barbara Sacha 5401 Old Court Rd, Randallstown, MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>NELLIE LORETTA SHIFFLETT</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>0258</b> M	
4. SOCIAL SECURITY NUMBER <b>215-32.6883</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>58</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06-13-33</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>BALTIMORE COUNTY GENERAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>RANDALSTOWN</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b>BALTIMORE</b>		10c. CITY, TOWN OR LOCATION <b>WOODLAWN</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				10e. STREET AND NUMBER <b>6029 GWYNN OAK AVE</b>			
10f. ZIP CODE <b>21207</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>5th</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Homemaker</b>		16b. KIND OF BUSINESS/INDUSTRY <b>Own Home</b>	
17. FATHER'S NAME (First, Middle, Last) <b>Richard Landacre</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Dantie Stewart</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Patricia A. Goodrich</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1096 Sacramento Ct., Sykesville, MD 21784</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Good Shepherd Cemetery 8/14</b>		20c. LOCATION — City or Town, State <b>Ellicott City, MD</b>		20d. DATE <b>8/14</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Spina Valley</b> <b>M00535</b>				22. NAME AND ADDRESS OF FACILITY <b>Slack Funeral Home Ellicott City, Maryland 21043</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. Arteriosclerotic Cardiovascular Disease</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST  b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>William E. Ford</b>				29c. LICENSE NUMBER <b>011171</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>E. P. Williams Sr. 405 Frederick Ave CATONSVILLE</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <b>J. Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 28 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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EX-111

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21985									
CERTIFICATE OF DEATH				REG. NO.													
1. DECEDENT'S NAME (First, Middle, Last) <b>AKA EARL ISIDORE SAYE</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>				3. TIME OF DEATH <b>3:42 A M</b>									
4. SOCIAL SECURITY NUMBER <b>216-44-8837</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		IF UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		IF UNDER 24 HRS. HOURS <b></b> MIN. <b></b>		7. DATE OF BIRTH (Month, Day, Year) <b>11-20-11</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>					
9a. FACILITY NAME (If not institution, give street and number) <b>LIBERTY MEDICAL CENTER</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b></b>							
10a. STATE <b>MARYLAND</b>				10b. COUNTY <b></b>				10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>2906 TERRY DR., APT. D</b>						10f. ZIP CODE <b>21209</b>				10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WII - ARMY</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify: <b></b>				14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>									
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (1-4 or 5+) <b></b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>PROOFREADER</b>				16b. KIND OF BUSINESS/INDUSTRY <b>U. S. GOVERNMENT</b>									
17. FATHER'S NAME (First, Middle, Last) <b>LOUIS SAYE</b>						18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>IDA SIDLIN</b>											
19a. INFORMANT'S NAME (Type/Print) <b>MR. MELVIN COHN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>6327 MONIKA PLA., APT. 605 BALTIMORE, MD 21207</b>													
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify) <b></b>		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>HEBREW FRIENDSHIP 8/11/91</b>				DATE <b></b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>									
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney J. Sullivan</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>													
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>a. POSSIBLE ASPIRATION PNEUMONIA</b> DUE TO (OR AS A CONSEQUENCE OF): <b>b. POSSIBLE ACUTE MYOCARDIAL INFARCTION</b> DUE TO (OR AS A CONSEQUENCE OF): <b>WITH</b> <b>c. CARDIAC ARRHYTHMIAS</b> DUE TO (OR AS A CONSEQUENCE OF): <b>d. END STAGE RENAL FAILURE</b> <b>Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>												Approximate Interval Between Onset and Death <b></b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>RENAL CALCULI</b> <b>DEMENTIA.</b>												24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify) <b></b>													
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 7 <input type="checkbox"/> Homicide				28a. DATE OF INJURY (Month, Day, Year) <b></b>		28b. TIME OF INJURY M <b></b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED <b></b>							
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify) <b></b>						28f. LOCATION (Street and Number or Rural Route Number, City or Town, State) <b></b>											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.												29b. SIGNATURE AND TITLE OF CERTIFIER <i>Sudhir Patel</i> M.D.		29c. LICENSE NUMBER <b>D 23300</b>		29d. DATE SIGNED (Month, Day, Year) <b>8.10.91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>SUDHIR. PATEL 2600 LIBERTY RD. BALTO MD. 21215</b>																	
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>													

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Julia VICTORIA Thompson</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>08</b> YEAR <b>91</b>		3. TIME OF DEATH <b>M</b>	
4. SOCIAL SECURITY NUMBER <b>219-28-0576</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>66</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12-17-24</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>107 LaRue Square-South</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH <b>MD</b>	
RESIDENCE OF DECEDENT							
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE, MD</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>107 LaRUE SQUARE SOUTH</b>				10f. ZIP CODE <b>21225</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>6TH</b> College (1-4 or 5+) <b>DOMESTIC</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>DOMESTIC</b>		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>ALBERT WISE</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>LOUISE SURGEON</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MARLENE COX</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>107 LARUE SQUARE SOUTH/BALTO., MD 21225</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>BALTIMORE NAT. CEM.</b>		DATE		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Calvin L. Williams</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH F.H. 1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>a. non-small cell cancer left lung</b>							
DUE TO (OR AS A CONSEQUENCE OF):							
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST							
b. DUE TO (OR AS A CONSEQUENCE OF):							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input checked="" type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Could not be determined <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)				28g. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Chad</i> <b>MD</b>				29c. LICENSE NUMBER <b>022782</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Harbor Hospital Center</b> <b>Aron W. Berkman MD</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1 FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Robert Leroy TODD</b>						2. DATE OF DEATH MONTH <b>8</b> DAY <b>13</b> YEAR <b>91</b>		3. TIME OF DEATH <b>4:15 a.m.</b>	
4. SOCIAL SECURITY NUMBER <b>212-16-2456</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>70</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>7-27-21</b>		8. BIRTHPLACE (State or Foreign Country) <b>MD</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Franklin Square Hospital</b>						9b. CITY, TOWN OR LOCATION OF DEATH <b>Rossville</b>		9c. COUNTY OF DEATH <b>Baltimore</b>	
10a. STATE <b>MD</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>				10d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
10e. STREET AND NUMBER <b>1010 Chesaco Ave.</b>				10f. ZIP CODE <b>21237</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>			
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES <b>WWII</b>		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>		
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>8</b> College (1-4 or 5+) <b>/</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Supervisor</b>			16b. KIND OF BUSINESS/INDUSTRY <b>Martin Marietta</b>				
17. FATHER'S NAME (First, Middle, Last) <b>John M. Todd</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Clara M. Mixture</b>					
19a. INFORMANT'S NAME (Type/Print) <b>Randy Todd</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>5539 Todd Ave. Baltimore, MD 21206</b>					
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Baltimore National</b>			20c. LOCATION — City or Town, State <b>Catonsville, MD</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>[Signature]</i>				22. NAME AND ADDRESS OF FACILITY <b>Cvach/Rosedale Funeral Home 1211 Chesaco Ave.</b>					
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.									Approximate Interval Between Onset and Death
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Congestive Heart Failure</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
<b>Myocardial Infarction</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
<b>Arteriosclerotic Cardiovascular Disease</b>									
DUE TO (OR AS A CONSEQUENCE OF):									
Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST									
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.									
24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO									24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.									
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year)	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. James D'Orta 9000 Franklin Square Drive Baltimore, MD 21237</b>									
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>[Signature]</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) <b>JACK H TANTHOFF</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>8</b> YEAR <b>91</b>		3. TIME OF DEATH <b>11:25 A M</b>	
4. SOCIAL SECURITY NUMBER <b>487-16-4391A</b>		5. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>79</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>03-09-12</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL OF BALTIMORE</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
RESIDENCE OF DECEASED							
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>2500 W. BELVEDERE AVE., APT. 713</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>	
15. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12</b> College (14 or 5+) <b>College</b>		15a. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>CLERK</b>		15b. KIND OF BUSINESS/INDUSTRY <b>RETAIL SALES</b>			
17. FATHER'S NAME (First, Middle, Last) <b>BARNEY TANHOFF</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>CELIA ZVERIN</b>			
19a. INFORMANT'S NAME (Type/Print) <b>MRS. YETTA TANHOFF</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2500 W. BELVEDERE AVE., APT. 713 BALTO., MD 21215</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MIKRO KODESH-BETH ISRAEL</b>		DATE <b>8/9/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Isa Levinson</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS. INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) →		a. <b>CARDIOGENIC SHOCK</b>				Approximate Interval Between Onset and Death <b>30 min</b>	
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST		b. <b>HEART FAILURE</b>				5+ years	
		c. <b>ISCHEMIC HEART DISEASE</b>				10+ years	
		d. <b>DIABETES - NON INSULIN DEPENDANT</b>					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
		28d. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28e. DESCRIBE HOW INJURY OCCURRED			
		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)					
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Hugh Brodie</i> <b>HUGH BRODIE MDCB INTERN</b>				29c. LICENSE NUMBER <b>SINAI RESIDENT</b>		29d. DATE SIGNED (Month, Day, Year) <b>8-8-91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Dr. HUGH M. BRODIE, SINAI HOSPITAL, BELVIDERE GREENSPRING, BALTIMORE MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>8-8-91</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendall</i>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: Item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21989

1. DECEDENT'S NAME (First, Middle, Last) <b>LEMMIE WILSON</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>9</b> YEAR <b>91</b>		3. TIME OF DEATH M					
4. SOCIAL SECURITY NUMBER <b>214-70-9402</b>		6. SEX 1 <input checked="" type="checkbox"/> M 2 <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>33</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>1/6/1958</b>		9. BIRTHPLACE (State or Foreign Country) <b>Louisiana</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>4663 Delaware Ave (Res.)</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>				9c. COUNTY OF DEATH			
RESIDENCE OF DECEDENT											
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>				10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>4663 DELAWARE AVENUE</b>				10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS 1 <input checked="" type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yea or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:			14. RACE — American Indian, Black, White, etc. Specify: <b>Black</b>				
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)			16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)			16b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>EMEAL WILSON</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>OLLIE MOSES</b>							
19a. INFORMANT'S NAME (Type/Print) <b>EMEAL WILSON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>2215 N. MONROE ST. BALTIMORE, MD 21217</b>							
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEMETERY</b>			20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>				
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>				22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Probable heart myocardial infarction?</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>Severe Hypertensive Cardiovascular Disease</b>								24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>E. J. ...</i>				29c. LICENSE NUMBER <b>D10152</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/13/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type/Print) <b>El. ... 419 Redwood St. Balto 21201</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE							

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1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>SHIRLEY WATSON</b>		2. DATE OF DEATH MONTH <b>08</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>7:48 P</b>	
4. SOCIAL SECURITY NUMBER <b>220-36-9739</b>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>49</b> YRS.	
7. DATE OF BIRTH (Month, Day, Year) <b>3/3/1942</b>		8. BIRTHPLACE (State or Foreign Country) <b>BALTIMORE, MD</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>			9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH
RESIDENCE OF DECEDENT					
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>4638 REISTERSTOWN ROAD</b>			10f. ZIP CODE <b>21215</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input checked="" type="checkbox"/> Married 3 <input type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:	
14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (14 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY	
17. FATHER'S NAME (First, Middle, Last) <b>HARLEY ENGLISH</b>			18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>FANNIE PARKER</b>		
19a. INFORMANT'S NAME (Type/Print) <b>FANNIE WILLIAMS</b>			19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>3805 FAIRVIEW AVE BALTIMORE, MD 21207</b>		
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>KING MEMORIAL PARK</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MD</b>	
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Leroy O. Dyett</i>			22. NAME AND ADDRESS OF FACILITY <b>LEROY O. DYETT &amp; SON FUNERAL HOME 4600 LIBERTY HEIGHTS AVENUE 21207</b>		
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.					
IMMEDIATE CAUSE (Final disease or condition resulting in death) → a. <b>ARTEROSCLEROTIC CARDIOVASCULAR DISEASE</b> DUE TO (OR AS A CONSEQUENCE OF):					
Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST					
b. DUE TO (OR AS A CONSEQUENCE OF):					
c. DUE TO (OR AS A CONSEQUENCE OF):					
d.					
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>MORBID OBESITY</b>					
24a. WAS AN AUTOPSY PERFORMED? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input checked="" type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)			
27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending investigation 6 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M	
28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.					
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Shirley F. Watson</i>		29c. LICENSE NUMBER <b>O.C.M.E.</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/13/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>MARIO T. GALLE JR. MD 111 PENN STREET, BALTIMORE, MARYLAND 21201</b>					
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>		32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is checked, item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

FOR STATE REGISTRAR  
STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH  
REG. NO.

91 21991

1. DECEDENT'S NAME (First, Middle, Last) <b>JOSEPH WEINSTEIN</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>11</b> YEAR <b>91</b>		3. TIME OF DEATH <b>9:55 AM</b>					
4. SOCIAL SECURITY NUMBER <b>212-32-4442</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>88</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>06/02/08</b>		8. BIRTHPLACE (State or Foreign Country) <b>RUSSIA</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSP. OF BALT. INC.</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH			
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>7203 BROOKCREST WAY, APT. A-3</b>				10f. ZIP CODE <b>21208</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <input type="checkbox"/> College (1-4 or 5+) <input checked="" type="checkbox"/>		18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>ACCOUNTANT</b>		18b. KIND OF BUSINESS/INDUSTRY <b>ACCOUNTING</b>							
17. FATHER'S NAME (First, Middle, Last) <b>EPHRIAM WEINSTEIN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>BESSIE (UNKNOWN)</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MRS. JUDY FELDMAN</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>23 RAISIN TREE CIR. BALTIMORE, MD 21208</b>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of place, City or Town, State, Zip Code) <b>ARLINGTON (CHIZUK AMUNO) 8/12/91 BALTIMORE, MD</b>		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Sydney L. Stillman</i>				22. NAME AND ADDRESS OF FACILITY <b>SOL LEVINSON &amp; BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>RESPIRATORY FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): <b>PNEUMONIA</b> Sequently list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF): DUE TO (OR AS A CONSEQUENCE OF):								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input type="checkbox"/> NO		HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA		OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		26. PLACE OF DEATH (Check only one) <b>SINAI HOSP. BALTIMORE</b>					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>M. A. Mah' moud</i> , <b>HOUSE STAFF</b>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>08/11/91</b>					
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. M. A. MAH' MOUD, DEPT. OF INTERNAL MED., SINAI HOSP., BALT. 21215 MD</b>											
31. DATE FILED (Month, Day, Year) <b>08 AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

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**STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH**

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1 - FOR  
STATE  
REGISTRAR

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>ALFRED YOUNG</b>				2. DATE OF DEATH MONTH DAY YEAR <b>AUGUST 9, 1991</b>		3. TIME OF DEATH <b>10:00 p.m.</b>	
4. SOCIAL SECURITY NUMBER <b>220-20-2225</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>64</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>6-1-27</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>MARYLAND GENREAL HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE CITY</b>		9c. COUNTY OF DEATH <b>BALTIMORE</b>	
10a. STATE <b>MARYLAND</b>				10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE CITY</b>	
10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO				10e. STREET AND NUMBER <b>1611 DIVISION ST. 2ND FL.</b>			
10f. ZIP CODE <b>21217</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>LAYFIELD WONGUS</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>EMMA YOUNG</b>			
19a. INFORMANT'S NAME (Type/Print) <b>JAMES THOMAS</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>812 W. LANVALE ST. 3RD FL. BALTO., MD. 21217</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VET. CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD.</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Portia Glendon</i>				22. NAME AND ADDRESS OF FACILITY <b>WM.C. MARCH FUNERAL HOME 4300 WABASH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.  IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>MILIARY TUBERCULOSIS</b> DUE TO (OR AS A CONSEQUENCE OF):  Sequitally list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d.							Approximate Interval Between Onset and Death
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO							24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO
26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide 3 <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>	
28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)	
29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>G. M. Tanous M.D.</i>				29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/9/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>GEORGE MTANOUS, M.D. c/o MARYLAND GENERAL HOSPITAL</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 14 1991</b>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Rendell</i>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL DR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 2 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Page 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>Gracie Allen</b>				2. DATE OF DEATH MONTH DAY YEAR <b>August 9, 1991</b>		3. TIME OF DEATH <b>3:45 P M</b>	
4. SOCIAL SECURITY NUMBER		5. SEX <input type="checkbox"/> M <input type="checkbox"/> F	6. AGE (In yrs. last birthday) <b>62</b> YRS.	7. DATE OF BIRTH (Month, Day, Year) <b>8/3/29</b>		8. BIRTHPLACE (State or Foreign Country) <b>Chester, VA</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Maryland General Hospital</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore City</b>		9c. COUNTY OF DEATH	
10a. STATE <b>Md</b>		10b. COUNTY <b>City</b>		10c. CITY, TOWN OR LOCATION <b>Baltimore</b>		10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>726 Reservoir St.</b>				10f. ZIP CODE		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>black</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		16b. KIND OF BUSINESS/INDUSTRY			
17. FATHER'S NAME (First, Middle, Last) <b>John Allen</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Emma Allen</b>			
19a. INFORMANT'S NAME (Type/Print) <b>Dorothy Tutt</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>726 Reservoir St.</b>			
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>MD NAT. Mem. Western St. 8/13</b>		20c. LOCATION — City or Town, State <b>Catonsville, Md</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Willie M. Parson</b>				22. NAME AND ADDRESS OF FACILITY <b>Willie M. Parson T/A Carolina Funeral Services 21229</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.							
IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Pancreatic Cancer</b>							
a. DUE TO (OR AS A CONSEQUENCE OF):							
b. <b>Hyperkalemia</b>							
c. DUE TO (OR AS A CONSEQUENCE OF):							
d.							
23. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.							
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input type="checkbox"/> Inpatient <input checked="" type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)					
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO	
28d. DESCRIBE HOW INJURY OCCURRED				28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)			
28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Notar Public</b>				29c. LICENSE NUMBER <b>D37928</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>2435 West Belvedere Ave Suite 22 Baltimore MD 21215</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 15 1991</b>		32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>					

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, P.O. BOX 68760, BALTIMORE, MARYLAND 21215-0020

TO THE FUNERAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3125



91 21994

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <b>William E Allen</b>				2. DATE OF DEATH MONTH <b>8</b> DAY <b>12</b> YEAR <b>91</b>		3. TIME OF DEATH <b>1030 P M</b>	
4. SOCIAL SECURITY NUMBER <b>217 24 5471</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <b>63</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>11-3-27</b>	
9a. FACILITY NAME (If not institution, give street and number) <b>Loch Raven VA Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>		9c. COUNTY OF DEATH	
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>		10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO	
10e. STREET AND NUMBER <b>3204 PRESBURY STREET</b>				10f. ZIP CODE <b>21216</b>		10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO IF YES, GIVE WAR OR OATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>BLACK</b>	
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5+) <b>College</b>		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>MAINTENANCE</b>		16b. KIND OF BUSINESS/INDUSTRY <b>UNIVERSITY HOSPITAL</b>			
17. FATHER'S NAME (First, Middle, Last) <b>WILLIAM P. ALLEN</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>NOVELLA PRICE</b>			
19a. INFORMANT'S NAME (Type/Print) <b>GLADYS PENNINGTON</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>Apt. 204</b> <b>755 W. LEXINGTON STREET/BALTO., MD 21201</b>			
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		20b. PLACE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GARRISON FOREST VA CEM.</b>		20c. LOCATION — City or Town, State <b>OWINGS MILLS, MD</b>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Signette K. Jones</i>				22. NAME AND ADDRESS OF FACILITY <b>WM. C. MARCH F.H./1101 E. NORTH AVE.</b>			
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>Sepsis</b> Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or Injury that initiated events resulting in death) LAST <div style="display: flex; justify-content: space-between;"> <div>           a. DUE TO (OR AS A CONSEQUENCE OF): <b>Diverticulitis</b>            b. DUE TO (OR AS A CONSEQUENCE OF): <b>Hodgkins Disease</b>            c. DUE TO (OR AS A CONSEQUENCE OF): <b>Hodgkins Disease</b>            d.         </div> <div>           Approximate Interval Between Onset and Death  <b>3 days</b>  <b>1 month</b>  <b>7 months</b> </div> </div>							
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
						24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)		27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 6 <input type="checkbox"/> Could not be determined 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide		28a. DATE OF INJURY (Month, Day, Year)	
		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
		28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Theresa MD 0391</i>				29c. LICENSE NUMBER <b>4V35427ABD91</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/12/91</b>	
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>Adam S. Bright, M.D. 3900 Loch Raven Blvd 21218</b>							
31. DATE FILED (Month, Day, Year) <b>AUG 15 1991</b>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i> <b>Baltimore, MD</b>			

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After the death certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

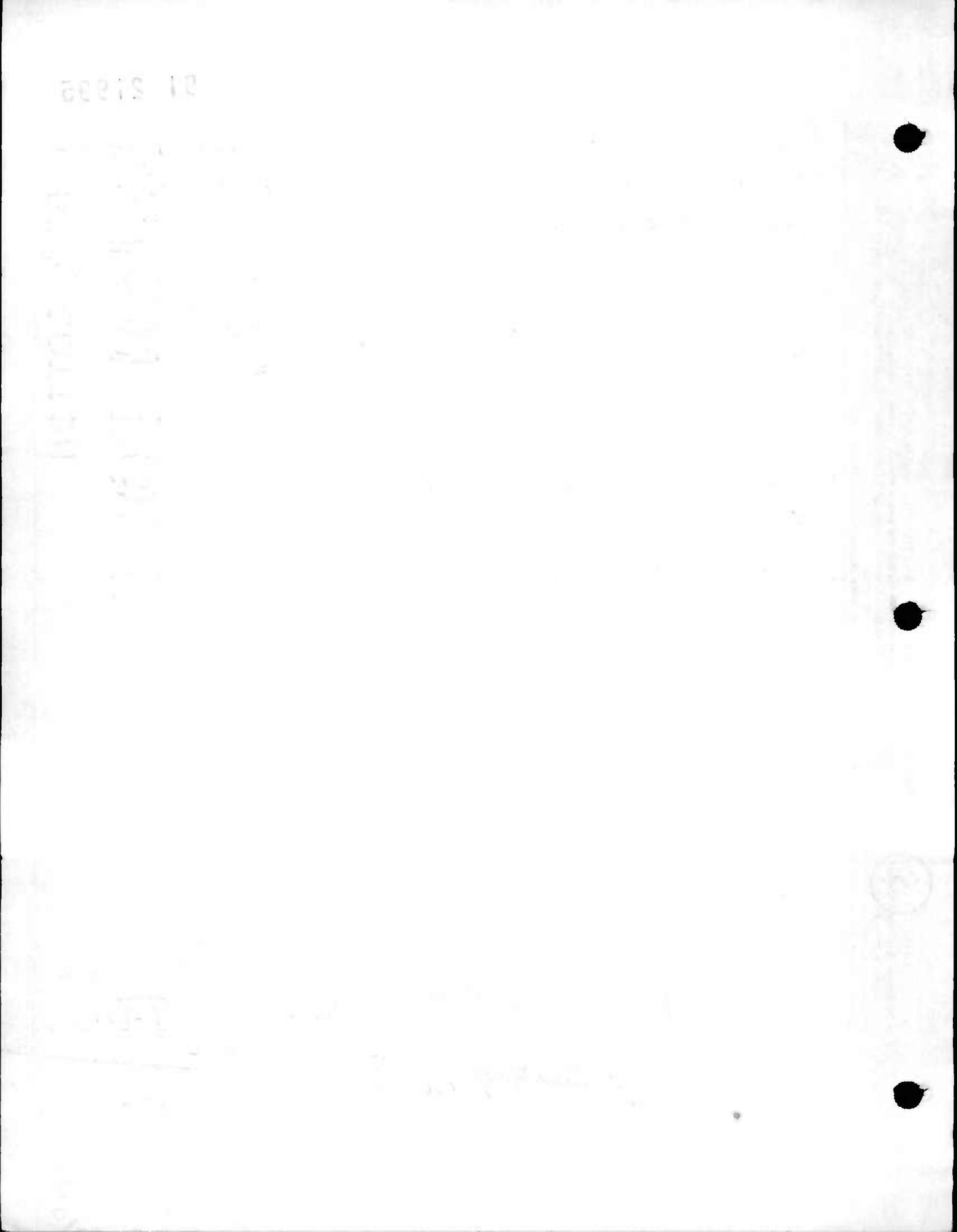
1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21995

1. DECEDENT'S NAME (First, Middle, Last) <b>WILLIAM H BELL</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>12</b> YEAR <b>1991</b>				3. TIME OF DEATH <b>04 04 A M</b>					
4. SOCIAL SECURITY NUMBER <b>234-18-0865</b>		5. SEX <b>1</b> <input checked="" type="checkbox"/> M <input type="checkbox"/> F	6. AGE (in yrs. last birthday) <b>83</b> YRS.	IF UNDER 1 YEAR MONTHS <b>03</b> DAYS <b>07</b>		IF UNDER 24 HRS. HOURS <b>08</b> MIN. <b>00</b>		7. DATE OF BIRTH (Month, Day, Year) <b>03/07/08</b>		8. BIRTHPLACE (State or Foreign Country) <b>W. VA.</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>FRANCIS SCOTT KEY MEDICAL CENTER</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH <b>BALTIMORE</b>					
10a. STATE <b>MD</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTO.</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					
10e. STREET AND NUMBER <b>1046 DildNorth Point Rd</b>				10f. ZIP CODE <b>21224</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>white</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary <input checked="" type="checkbox"/> (9-12) College (1-4 or 5+)		16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>LABOR</b>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last) <b>Unknown</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Unknown</b>									
19a. INFORMANT'S NAME (Type/Print) <b>SARAH WALLACE</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1497 Weyburn Rd Rosedale md</b>									
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>WESTERN STAR CEM 8/11</b>				20c. LOCATION — City or Town, State <b>BALTO.</b>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Betts Funeral Home</b>				22. NAME AND ADDRESS OF FACILITY <b>1129 N. CAROLINE ST</b>									
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>ASPIRATION PNEUMONIA</b> a. DUE TO (OR AS A CONSEQUENCE OF): b. DUE TO (OR AS A CONSEQUENCE OF): c. DUE TO (OR AS A CONSEQUENCE OF): d. DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.										Approximate interval Between Onset and Death <b>4 days</b>			
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.				29b. SIGNATURE AND TITLE OF CERTIFIER <b>[Signature] MD</b>				29c. LICENSE NUMBER <b>D-21586</b>		29d. DATE SIGNED (Month, Day, Year) <b>08/12/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>AGBOR N. EGBEWATT, MD — FRANCIS SCOTT KEY HOSPITAL</b>													
31. DATE FILED (Month, Day, Year) <b>AUG 15 1991</b>				32. REGISTRAR'S SIGNATURE <b>[Signature]</b>									

01 51992



TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law provides that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR STATE REGISTRAR				STATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE				91 21996			
CERTIFICATE OF DEATH				REG. NO.							
1. DECEDENT'S NAME (First, Middle, Last) <b>Stephanie Betz</b>				2. DATE OF DEATH MONTH: <b>8</b> DAY: <b>14</b> YEAR: <b>91</b>				3. TIME OF DEATH <b>9:20 A.M.</b>			
4. SOCIAL SECURITY NUMBER <b>099-26-5668</b>		5. SEX <input type="checkbox"/> M <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birth day) <b>96</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>5/5/1895</b>		8. BIRTHPLACE (State or Foreign Country) <b>Czechoslovakia</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>Francis Scott Key Medical Center</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>Baltimore</b>				9c. COUNTY OF DEATH <b>Baltimore</b>			
10a. STATE <b>Md.</b>		10b. COUNTY <b>Baltimore</b>		10c. CITY, TOWN OR LOCATION <b>Dundalk</b>				10d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			
10e. STREET AND NUMBER <b>2917 Dunmurry Rd. Apt. A</b>				10f. ZIP CODE <b>21222</b>				10g. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
11. MARITAL STATUS <input type="checkbox"/> Never Married <input type="checkbox"/> Married <input checked="" type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No—If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <b>White</b>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) <b>High School</b>				16a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <b>Cook</b>				16b. KIND OF BUSINESS/INDUSTRY <b>Restaurant</b>			
17. FATHER'S NAME (First, Middle, Last) <b>Johann Snieder</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>Anna Kepple</b>							
19a. INFORMANT'S NAME (Type/Print) <b>Martha Sheppard</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>239 St. Helena Ave., Balto., Md. 21222</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>Green Mount Crematory 8-15-91 Balto., Md.</b>		20c. LOCATION — City or Town, State							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <b>Putra S. Walton</b>				22. NAME AND ADDRESS OF FACILITY <b>Bradley-Ashton Funeral Home, INnc. 2134 Willow Spring Rd., Dundalk, Md. 21222</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. <b>IMMEDIATE CAUSE (Final disease or condition resulting in death) →</b> <b>CHF &amp; LVH</b> <b>Due TO (OR AS A CONSEQUENCE OF):</b> <b>Systolic HTN</b> <b>Due TO (OR AS A CONSEQUENCE OF):</b> <b>Renal tubular acidosis / Renal Insuff.</b> <b>Due TO (OR AS A CONSEQUENCE OF):</b> <b>COPD</b> <b>Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST</b>								Approximate Interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <b>C. diff. Diarrhea</b>								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		26. PLACE OF DEATH (Check only one) <b>HOSPITAL:</b> <input type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> OOA <b>OTHER:</b> <input checked="" type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)									
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input checked="" type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>W.B. Greenough Jr.</b>						29c. LICENSE NUMBER <b>D04383</b>		29d. DATE SIGNED (Month, Day, Year) <b>8/14/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>William B. Greenough Jr.</b>											
31. DATE FILLED (Month, Day, Year) <b>AUG 15 1991</b>				32. REGISTRAR'S SIGNATURE <b>Julia Davidson-Randall</b>							

20015 10

20015 10

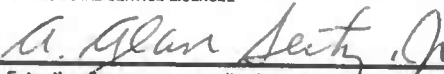
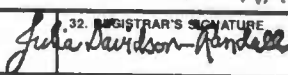
EMERSON BOND

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician.  
TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.  
IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21997

1. DECEDENT'S NAME (First, Middle, Last) <b>EDELBERT J. BUTTNER</b>				2. DATE OF DEATH MONTH <b>08</b> DAY <b>10</b> YEAR <b>91</b>		3. TIME OF DEATH <b>2:02AM</b>					
4. SOCIAL SECURITY NUMBER <b>212-03-2528</b>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (in yrs. last birthday) <b>74</b> YRS.		7. DATE OF BIRTH (Month, Day, Year) <b>12 09 16</b>		8. BIRTHPLACE (State or Foreign Country) <b>MARYLAND</b>			
9a. FACILITY NAME (If not institution, give street and number) <b>SINAI HOSPITAL</b>				9b. CITY, TOWN OR LOCATION OF DEATH <b>BALTIMORE</b>				9c. COUNTY OF DEATH			
10a. STATE <b>MARYLAND</b>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <b>BALTIMORE</b>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <b>1049 ROLAND HEIGHTS AVENUE</b>				10f. ZIP CODE <b>21211</b>		10g. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
11. MARITAL STATUS <input type="checkbox"/> Never Married <input checked="" type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:		14. RACE — American Indian, Black, White, etc. Specify: <b>WHITE</b>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <b>12TH</b> College (1-4 or 5 +)				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.)		18b. KIND OF BUSINESS/INDUSTRY					
17. FATHER'S NAME (First, Middle, Last) <b>Fred J. Buttner aka Godfred Buettner</b>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <b>MARY FLORENCE WAGNER</b>							
19a. INFORMANT'S NAME (Type/Print) <b>MARY C. BUTTNER</b>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <b>1049 ROLAND HEIGHTS AVENUE, BALTO., MD. 21211</b>							
20a. METHOD OF DISPOSITION <input type="checkbox"/> Burial <input checked="" type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)		20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <b>GREEN MOUNT CEMETERY 8/13/91</b>		20c. LOCATION — City or Town, State <b>BALTIMORE, MARYLAND</b>							
21. SIGNATURE OF FUNERAL SERVICE LICENSEE 				22. NAME AND ADDRESS OF FACILITY <b>A. ALAN SEITZ, JR. FUNERAL HOME 3818 ROLAND AVENUE, BALTO., MD. 21211</b>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <b>CARDIAC ARREST</b> DUE TO (OR AS A CONSEQUENCE OF): Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST <b>CONGESTIVE HEART FAILURE</b> DUE TO (OR AS A CONSEQUENCE OF): Approximate Interval Between Onset and Death <b>30 min</b> <b>30 YRS.</b>											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.								24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Could not be determined		28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY <b>M</b>		28c. INJURY AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED			
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <b>Gurpreet Kochar Narula, M.B.B.S.</b>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <b>8/10/91</b>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <b>DR. GURPREET KOCHAR NARULA</b>											
31. DATE FILED (Month, Day, Year) <b>AUG 15 1991</b>				32. REGISTRAR'S SIGNATURE 							

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31 32 33 34 35 36 37 38 39 40 41 42 43 44 45 46 47 48 49 50 51 52 53 54 55 56 57 58 59 60 61 62 63 64 65 66 67 68 69 70 71 72 73 74 75 76 77 78 79 80 81 82 83 84 85 86 87 88 89 90 91 92 93 94 95 96 97 98 99 100

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91 21998

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED'S NAME (First, Middle, Last) YVONNE IOLA BOERUM				2. DATE OF DEATH AUGUST 11, 1991		3. TIME OF DEATH 5:30 P M	
4. SOCIAL SECURITY NUMBER 577-20-8123		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) 83 YRS.		7. DATE OF BIRTH MAY 24, 1908	
8. BIRTHPLACE (State or Foreign) MD.				9. COUNTY OF DEATH MONTGOMERY			
10. FACILITY NAME (If not institution, give street and number) SHADY GROVE ADV. NURSING CENTER				11. CITY, TOWN OR LOCATION OF DEATH ROCKVILLE		12. COUNTY OF DEATH MONTGOMERY	
13. RESIDENCE OF DECEASED				14. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO			
15a. STATE MD.		15b. COUNTY MONTGOMERY		15c. CITY, TOWN OR LOCATION CLARKSBURG		15d. INSIDE CITY LIMITS? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
16. STREET AND NUMBER 11415 HAWKS ROAD				17. ZIP CODE 20871		18. CITIZEN OF WHAT COUNTRY? USA	
19. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		20. WAS DECEASED EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		21. WAS DECEASED OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:		22. RACE — American Indian, Black, White, etc. Specify: WHITE	
23. DECEASED'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) 12 College (1-4 or 5+) 0		24. DECEASED'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) MANAGER SCHOOL CAFETERIA		25. KIND OF BUSINESS/INDUSTRY MONT. COUNTY SCHOOLS			
26. FATHER'S NAME (First, Middle, Last) HARRY NEHOUSE				27. MOTHER'S NAME (First, Middle, Maiden Surname) BESSIE BOWMAN			
28. INFORMANT'S NAME (Type/Print) ELEANOR NEHOUSE				29. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) SAME AS # 10			
30. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)		31. PLACE OF DISPOSITION (Name of cemetery, crematory or other) SALEM CEMETERY		32. LOCATION — City or Town, State CEDAR GROVE, MD.			
33. SIGNATURE OF FUNERAL SERVICE LICENSEE Muriel H. Barber				34. NAME AND ADDRESS OF FACILITY MURIEL H. BARBER FUNERAL HOME 21525 LAYTONSVILLE ROAD LAYTONSVILLE, MD. 20882			
35. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → Bilateral pneumonias DUE TO (OR AS A CONSEQUENCE OF): Dementia of Alzheimer's type Respiratory failure Gastrointestinal bleed Sequentially list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST						36. Approximate Interval Between Onset and Death	
37. PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.						38. 24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO	
39. 24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO							
40. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		41. 26. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input checked="" type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)					
42. 27. MANNER OF DEATH 1 <input checked="" type="checkbox"/> Natural 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 5 <input type="checkbox"/> Pending Investigation 6 <input type="checkbox"/> Could not be determined		43. 28a. DATE OF INJURY (Month, Day, Year)		44. 28b. TIME OF INJURY M		45. 28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
46. 28d. DESCRIBE HOW INJURY OCCURRED		47. 28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)		48. 28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)			
49. 29a. CERTIFIER (Check only one) 1 <input type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.							
50. 29b. SIGNATURE AND TITLE OF CERTIFIER S. Abulfarag				51. 29c. LICENSE NUMBER 813910		52. 29d. DATE SIGNED (Month, Day, Year) 8/12/91	
53. 30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (Item 27) (Type, Print) DR. SUHAIR ABULFARAG 19361 MONTGOMERY VILLAGE AVE. GAITHERSBURG, MD. 20879							
54. 31. DATE FILED (Month, Day, Year) AUG 15 1991							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21203-3146

DIVISION OF VITAL RECORDS, P.O. BOX 13146,

TO THE HOSPITAL OR AUTOPSY PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 6 may be retained by the hospital or attending physician. TO THE FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

1. FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

91 21999

1. DECEDENT'S NAME (First, Middle, Last) <i>Marquerite Brent</i>				2. DATE OF DEATH MONTH DAY YEAR <i>08 09 91</i>				3. TIME OF DEATH HOURS MIN. <i>1238</i>							
4. SOCIAL SECURITY NUMBER <i>579-56-4771</i>		5. SEX 1 <input type="checkbox"/> M 2 <input checked="" type="checkbox"/> F		6. AGE (In yrs. last birthday) YRS. <i>93</i>		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		7. DATE OF BIRTH (Month, Day, Year) <i>08 29 97</i>		8. BIRTHPLACE (State or Foreign Country) <i>Wash</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>Holy Cross Hospital</i>						9b. CITY, TOWN OR LOCATION OF DEATH <i>Silver Spring</i>						9c. COUNTY OF DEATH <i>Mont</i>			
10a. STATE <i>DC</i>		10b. COUNTY				10c. CITY, TOWN OR LOCATION <i>Washington</i>						10d. INSIDE CITY LIMITS? 1 <input checked="" type="checkbox"/> YES 2 <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>630 Irving St NW</i>						10f. ZIP CODE <i>20010</i>				10g. CITIZEN OF WHAT COUNTRY? <i>USA</i>					
11. MARITAL STATUS 1 <input type="checkbox"/> Never Married 2 <input type="checkbox"/> Married 3 <input checked="" type="checkbox"/> Widowed 4 <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES				13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. <i>Black</i>					
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (0-12) <i>12 Yrs</i> College (1-4 or 5+) <i>None</i>				18a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Record Clerk</i>				16b. KIND OF BUSINESS/INDUSTRY							
17. FATHER'S NAME (First, Middle, Last)						16. MOTHER'S NAME (First, Middle, Maiden Surname)									
19a. INFORMANT'S NAME (Type/Print) <i>Ken Stewart</i>						19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>12 Montrose Rd, Somerset, NJ 08873</i>									
20a. METHOD OF DISPOSITION 1 <input checked="" type="checkbox"/> Burial 2 <input type="checkbox"/> Cremation 3 <input type="checkbox"/> Removal from State 4 <input type="checkbox"/> Donation 5 <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arlington National</i>				DATE		20c. LOCATION — City or Town, State <i>Arlington, Va</i>					
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Hazel [Signature]</i>						22. NAME AND ADDRESS OF FACILITY <i>John T Rhines Co., Inc. 3015 12th St NE, DC 20017</i>									
23. PART I. Enter the diseases, or complications that caused this death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line. IMMEDIATE CAUSE (Final disease or condition resulting in death) → <i>Cardiopulmonary arrest</i> Sequitely list conditions, if any, leading to immediate cause. Enter UNDERLYING CAUSE (Disease or injury that initiated events resulting in death) LAST { <i>Rectal carcinoma with metastases</i>												Approximate interval Between Onset and Death			
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I.												24a. WAS AN AUTOPSY PERFORMED? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO		24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO	
25. WAS CASE REFERRED TO MEDICAL EXAMINER? 1 <input type="checkbox"/> YES 2 <input checked="" type="checkbox"/> NO				28. PLACE OF DEATH (Check only one) HOSPITAL: 1 <input checked="" type="checkbox"/> Inpatient 2 <input type="checkbox"/> ER/Outpatient 3 <input type="checkbox"/> DOA OTHER: 4 <input type="checkbox"/> Nursing Home 5 <input type="checkbox"/> Residence 6 <input type="checkbox"/> Other (Specify)											
27. MANNER OF DEATH 1 <input type="checkbox"/> Natural 5 <input type="checkbox"/> Pending Investigation 2 <input type="checkbox"/> Accident 3 <input type="checkbox"/> Suicide 4 <input type="checkbox"/> Homicide 6 <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? 1 <input type="checkbox"/> YES 2 <input type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED					
28a. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)											
29a. CERTIFIER (Check only one) 1 <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. 2 <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.															
29b. SIGNATURE AND TITLE OF CERTIFIER <i>[Signature]</i>						29c. LICENSE NUMBER		29d. DATE SIGNED (Month, Day, Year) <i>8/9/91</i>							
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print)															
31. DATE FILED (Month, Day, Year) <i>AUG 15 1991</i>				32. REGISTRAR'S SIGNATURE <i>John Davidson-Randall</i>											

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91 22000

1 - FOR  
STATE  
REGISTRARSTATE OF MARYLAND / DEPARTMENT OF HEALTH AND MENTAL HYGIENE  
CERTIFICATE OF DEATH

REG. NO.

1. DECEDENT'S NAME (First, Middle, Last) <i>Maurice Bernard Chapman</i>				2. DATE OF DEATH MONTH DAY YEAR <i>AUGUST 10, 1991</i>				3. TIME OF DEATH H M <i>6:52 P M</i>			
4. SOCIAL SECURITY NUMBER <i>217-68-1732</i>		5. SEX <input checked="" type="checkbox"/> M <input type="checkbox"/> F		6. AGE (In yrs. last birthday) <i>31</i> YRS.		7. DATE OF BIRTH (Month, Day, Year) <i>9-5-59</i>		8. BIRTHPLACE (State or Foreign Country) <i>MD</i>			
9a. FACILITY NAME (If not institution, give street and number) <i>THE JOHNS HOPKINS HOSPITAL</i>				9b. CITY, TOWN OR LOCATION OF DEATH <i>BALTIMORE</i>				9c. COUNTY OF DEATH <i>BALTIMORE CITY</i>			
RESIDENCE OF DECEDENT											
10a. STATE <i>MD</i>		10b. COUNTY		10c. CITY, TOWN OR LOCATION <i>BALTO.</i>				10d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
10e. STREET AND NUMBER <i>1503 E. Federal St</i>				10f. ZIP CODE <i>21213</i>				10g. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>			
11. MARITAL STATUS <input checked="" type="checkbox"/> Never Married <input type="checkbox"/> Married <input type="checkbox"/> Widowed <input type="checkbox"/> Divorced		12. WAS DECEDENT EVER IN U.S. ARMED FORCES? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO IF YES, GIVE WAR OR DATES		13. WAS DECEDENT OF HISPANIC ORIGIN? (Specify Yes or No— If yes, specify Cuban, Mexican, Puerto Rican, etc.) <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO Specify:				14. RACE — American Indian, Black, White, etc. Specify: <i>Negro</i>			
15. DECEDENT'S EDUCATION (Specify only highest grade completed) Elementary/Secondary (10-12) <input checked="" type="checkbox"/> College (1-4 or 5+) <input type="checkbox"/>				15a. DECEDENT'S USUAL OCCUPATION (Give kind of work done during most of working life. Do NOT use retired.) <i>Labor</i>				15b. KIND OF BUSINESS/INDUSTRY <i>—</i>			
17. FATHER'S NAME (First, Middle, Last) <i>Richard Campbell</i>				18. MOTHER'S NAME (First, Middle, Maiden Surname) <i>Carolyn Whitner</i>							
19a. INFORMANT'S NAME (Type/Print) <i>Carolyn Whitner</i>				19b. MAILING ADDRESS (Street and Number or Rural Route Number, City or Town, State, Zip Code) <i>1503 E. Federal St. BALTO. MD 21213</i>							
20a. METHOD OF DISPOSITION <input checked="" type="checkbox"/> Burial <input type="checkbox"/> Cremation <input type="checkbox"/> Removal from State <input type="checkbox"/> Donation <input type="checkbox"/> Other (Specify)				20b. PLACE AND DATE OF DISPOSITION (Name of cemetery, crematory or other place) <i>Arbutus Mem PK 8/16 BALTO. MD</i>				20c. LOCATION — City or Town, State <i>BALTO. MD</i>			
21. SIGNATURE OF FUNERAL SERVICE LICENSEE <i>Beth's Funeral Home</i>				22. NAME AND ADDRESS OF FACILITY <i>1129 N. Caroline St.</i>							
23. PART I. Enter the diseases, or complications that caused the death. Do not enter the mode of dying, such as cardiac or respiratory arrest, shock, or heart failure. List only one cause on each line.											
IMMEDIATE CAUSE (Final disease or condition resulting in death) →											
a. <i>hypotension</i> DUE TO (OR AS A CONSEQUENCE OF):											
b. <i>Bilateral pneumonia</i> DUE TO (OR AS A CONSEQUENCE OF):											
c. <i>chronic diarrhea</i> DUE TO (OR AS A CONSEQUENCE OF):											
d. <i>AIDS, end stage</i> DUE TO (OR AS A CONSEQUENCE OF):											
ACQUIRED IMMUNE DEFICIENCY SYNDROME											
PART II. Other significant conditions contributing to death but not resulting in the underlying cause given in Part I. <i>Anemia</i>											
24a. WAS AN AUTOPSY PERFORMED? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				24b. WERE AUTOPSY FINDINGS AVAILABLE PRIOR TO COMPLETION OF CAUSE OF DEATH? <input type="checkbox"/> YES <input type="checkbox"/> NO							
25. WAS CASE REFERRED TO MEDICAL EXAMINER? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO				26. PLACE OF DEATH (Check only one) HOSPITAL: <input checked="" type="checkbox"/> Inpatient <input type="checkbox"/> ER/Outpatient <input type="checkbox"/> DOA OTHER: <input type="checkbox"/> Nursing Home <input type="checkbox"/> Residence <input type="checkbox"/> Other (Specify)							
27. MANNER OF DEATH <input checked="" type="checkbox"/> Natural <input type="checkbox"/> Pending Investigation <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Could not be determined				28a. DATE OF INJURY (Month, Day, Year)		28b. TIME OF INJURY M		28c. INJURY AT WORK? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		28d. DESCRIBE HOW INJURY OCCURRED	
28e. PLACE OF INJURY — At home, farm, street, factory, office building, etc. (Specify)				28f. LOCATION (Street and Number or Rural Route Number, City or Town, State)							
29a. CERTIFIER (Check only one) <input checked="" type="checkbox"/> CERTIFYING PHYSICIAN: To the best of my knowledge, death occurred at the time, date and place, and due to the cause(s) and manner as stated. <input type="checkbox"/> MEDICAL EXAMINER: On the basis of examination and/or investigation, in my opinion, death occurred at the time, date and place, and due to the cause(s) and manner as stated.											
29b. SIGNATURE AND TITLE OF CERTIFIER <i>Daniel F. Pauly MD</i>				29c. LICENSE NUMBER <i>J2094</i>				29d. DATE SIGNED (Month, Day, Year) <i>8-10-91</i>			
30. NAME AND ADDRESS OF PERSON WHO COMPLETED CAUSE OF DEATH (ITEM 27) (Type, Print) <i>Daniel F. Pauly MD 600 N Wolfe St. Baltimore MD 21205</i>											
31. DATE FILED (Month, Day, Year) <i>AUG 15 1991</i>				32. REGISTRAR'S SIGNATURE <i>Julia Davidson-Randall</i>							

TO BE COMPLETED BY FUNERAL DIRECTOR

TO BE COMPLETED BY PHYSICIAN: MEDICAL CERTIFICATION

BALTIMORE, MARYLAND 21215-0020

DIVISION OF VITAL RECORDS, P.O. BOX 68760,

TO THE HOSPITAL OR ATTENDING PHYSICIAN: The law requires that this certificate be executed within 72 hours after death. Page 6 may be retained by the hospital or attending physician.

TO THE FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 5 should be detached for use as the burial-transit permit. Pages 1, 2, 3 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 28 is marked, or item 23 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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